MID-WILLAMETTE VALLEY COMMUNITY ACTION AGENCY (MWVCAA)

2026 Needs Assessment of Homelessness and Housing Stability

Integrated Findings and Supporting Reports

MARION AND POLK COUNTIES, OREGON

OCTOBER 2026

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INTEGRATED FINDINGS REPORT 2026

Needs Assessment of Homelessness and Housing Stability

MARION AND POLK COUNTIES, OREGON

HOUSING AND HOMELESSNESS COMMUNITY NEEDS ASSESSMENT

PREPARED FOR

Mid-Willamette Valley Community Action Agency

PREPARED BY

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DATE

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Woodson Insights Research + Evaluation (WIRE) thanks the Mid-Willamette Valley Community Action Agency (MWVCAA) for commissioning this work and for its partnership throughout. We also appreciate MWVCAA's Housing and Homelessness Advisory Council for their input throughout the process in revising survey questions, co-developing listening session guides, identifying locations for listening sessions and support in gathering data. We also extend sincere appreciation to the partner organizations across Marion and Polk Counties that hosted listening sessions, distributed flyers, recruited participants, verified the shelter inventory, and connected their communities to this assessment. Sessions were hosted in Salem, Monmouth, Stayton, Falls City, Woodburn, and Silverton at shelters, day centers, youth programs, community centers, and congregations.

Terms and Acronyms

Homeless services carry a specialized vocabulary, and several of its most common terms mean different things to different organizations. The definitions below establish how each term is used in this report. Program-level and inventory-specific definitions appear in the standalone landscape scan report.

Table 1. Terms and acronyms used in this report

Term	As used in this report
Chronic homelessness	A person with a disabling condition who has lived unsheltered, in a safe haven, or in an emergency shelter for at least 12 months. The 12 months can be continuous, or they can add up across four or more episodes in three years. A family qualifies when its head of household meets these criteria
Continuum of Care (CoC)	The HUD-designated body responsible for coordinating homelessness planning, funding, and policy across a defined geographic area. The CoC for Marion and Polk Counties is led locally by the Mid-Willamette Valley Homeless Alliance.
Coordinated Entry (CE)	The shared regional process intended to assess, prioritize, and refer people to housing resources through common access points and a common assessment.
Diversion	Rapid, flexible problem-solving that resolves a housing crisis without shelter entry, for example a mediated return to family or one-time financial help.
Emergency shelter (ES)	Short-term overnight sheltering intended for immediate crisis. Distinct from transitional housing, which is longer-stay and program-based.
Harm reduction	Harm reduction meets people where they are — reducing the negative consequences of substance use without requiring abstinence as a condition of service.
Homeless Management Information System (HMIS)	Homeless Management Information System, the shared client database used for federal reporting and funding.
Housing and Urban Development (HUD)	The federal agency that administers homeless assistance programs, sets the definitions of homelessness used in this report, and requires the annual Point-in-Time count and Housing Inventory Count.
Housing Inventory Count (HIC)	HUD's annual count of beds and units dedicated to serving people experiencing homelessness, taken the same night as the PIT count.
Household unit	A room or unit occupied by a family or household rather than an individual bed. This report estimates household units at three persons
Literally homeless	HUD's primary homeless category: lacking a fixed, regular, and adequate nighttime residence, including people who are unsheltered, in emergency

Term	As used in this report
	shelter, or in transitional housing. Includes shelter residents. Excludes people doubled up or in self-paid motels.
Low barrier	Minimal preconditions to access services, such as sobriety requirements, ID, or curfews, in order to reach people who might otherwise be precluded from services.
Medication-assisted treatment (MAT)	Medication-assisted treatment for substance use disorder, such as methadone or buprenorphine.
Peer support specialist	A trained staff member whose own lived experience of homelessness, mental health challenges, recovery, or a combination of these is part of their qualification for the role.
Point-in-Time (PIT) count	HUD's one-night census of people experiencing homelessness, conducted in late January. Communities count sheltered people every year and unsheltered people every other year, in odd-numbered years.
Permanent supportive housing (PSH)	Permanent housing paired with ongoing services such as case management, mental health care, and substance use treatment. Generally, for people with long homelessness histories and disabling conditions.
Rapid rehousing (RRH)	Short-term rental assistance plus services intended to move people quickly from homelessness into permanent housing.
Service provider	An organization, or a staff member of an organization, that delivers housing, sheltering, or supportive services to people experiencing or at risk of homelessness in Marion and Polk Counties. In this report, "provider" encompasses individuals in a range of roles, from frontline shelter and outreach staff to program managers and executive directors, working in homeless services and in allied sectors such as behavioral health and food assistance.
Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)	SSI: A federal needs-based benefit for people who are aged, blind, or disabled and who have limited income and resources. SSDI: A federal benefit for people with disabilities who have a qualifying work history and have paid into Social Security. Standard SSI-level income in this period sits near $994 per month, for an individual and $1,491 for a couple.
Sweep	Enforcement removal of an encampment, often with loss or disposal of belongings.
Transitional housing (TH)	Time-limited housing with program structure, intended as a bridge between shelter and permanent housing. Federal rules set a goal of moving residents into permanent housing within 24 months.
Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)	The standardized vulnerability assessment tool used at many Coordinated Entry access points to score and prioritize people for housing resources.

Term	As used in this report
Unduplicated count	A count of distinct individuals served across programs.
Unsheltered	Experiencing homelessness while staying in a place not designed for or ordinarily used as regular sleeping accommodation, including streets, sidewalks, parks, vehicles, tents and encampments, and abandoned buildings.
Youth and young adults	People under age 25 who are experiencing homelessness without a parent or guardian. This report groups them by age. Youth are ages 11 to 17. Young adults are ages 18 to 24.

Executive Summary

In 2025, the Point-in-Time Count identified 2,135 people experiencing homelessness across Marion and Polk Counties, up from 1,683 in 2023. **Nearly half of those counted reported that this was the first time in their lives they had lost housing**, while a large share of unsheltered individuals had been homeless for three years or longer. These counts describe the scale of the crisis. However, it does not explain how people got there, what they tried before they lost housing, what happened when they sought help, which parts of the response system are functioning, or what would have changed the outcome. The Mid-Willamette Valley Community Action Agency (MWVCAA) commissioned this assessment to answer those questions.

Woodson Insights Research + Evaluation (WIRE) conducted a mixed-methods needs assessment across both counties between March and August 2026. Eight evaluation questions co-created with MWVCAA guided the design. This report brings together five sources of evidence. The findings from the landscape scan, the community member survey, the service provider survey, and the listening session with community members and service providers are integrated into this report.

Sources of Evidence/Methods at a glance

Table 2. Sources of evidence and methods at a glance

Data source	Scale	Period
Landscape scan and shelter inventory	44 verified sheltering programs operated by 17 organizations	March to May 2026
Community member survey (English and Spanish)	161 complete responses (150 online, 11 phone-assisted)	May 12 to August 12, 2026
Service provider survey (English and Spanish)	90 provider staff across the region's organizations	May 12 to August 12, 2026
Listening sessions (English and Spanish)	8 sessions (7 with people with lived-experience, 1 with service providers); 56 participants with lived-experience and 9 service providers	May to August 2026
Secondary data	2023, 2025 and 2026 Point-in-Time counts,[1] Housing Inventory Count, and housing market indicators	2023 to 2026

Note. Survey figures are reported against the number of respondents answering each item (base number).

[1] The 2023 and 2025 Point-in-Time counts included both sheltered and unsheltered people. The 2026 count included sheltered people only, because HUD requires unsheltered counts every other year, in odd-numbered years.

The five findings to consider

Where providers and community members were asked about the same topics, they ranked the same barriers, needs, and pathways in nearly the same order.

1. Most people experiencing homelessness in the region are long-term residents, and for most, this is not their first episode. Among providers, 84%report that the majority of their clients became homeless in Marion or Polk County, and only 9% point to an origin outside the two counties. Among community member survey respondents, 42% grew up here or have lived here more than ten years, and among those who did move here, family ties outrank service availability as the reason by roughly three to one. Two-thirds of respondents had been homeless before, and 69% of listening session participants reported more than a year of homelessness in total. The dominant movement is intra-regional, toward Salem, along referral pathways the region itself has built.

2. Most people received no prevention support before losing housing. Sixty-nine percent of survey respondents entered homelessness without any prevention assistance at all. Among the 50 respondents who received support, food assistance was the most common form. Rental assistance reached 20 respondents of 161, and case management or a housing advocate reached three. Of those who received support, 40% said it was not enough to prevent the loss. Among respondents currently housed but at risk, rent and deposit assistance was the most cited need.

3. On paper, capacity nearly matches need. In practice, a bed that exists does not equal a bed a person can use. The region's 44 sheltering programs provide a combined capacity of roughly 2,111 sleeping spaces on a typical night, compared against a 2025 Point-in-Time count of 2,135 people. Sixty-four percent of programs carry waitlists. Fifteen of 44 accept walk-ins. More than a quarter of beds sit behind abstinence-with-testing requirements, and rules on pets, partners, records, and identification exclude identifiable groups. Ninety percent of survey respondents named at least one harm from contact with services or enforcement, and four of the five most selected harms describe experiences with services rather than conditions of homelessness itself.

4. Not knowing what exists is a barrier comparable in scale to the shortage of what exists. The most selected barrier among community members was not knowing what services are available or how to find them, at 48%, ahead of waitlists at 42%. This was supported by service providers, 78% of whom reported that clients do not know what services are available. Other barriers selected by community members included waitlists (42%), limited or no internet access (40%), and no working phone (18%). One of the most surprising barriers on the provider side seems to be Coordinated Entry, a system whose goal is facilitating access. **Of the 90 providers surveyed, not one selected the option that Coordinated Entry is working well.**

5. The system is most developed and centered in Salem, and distance remains a barrier. Salem holds roughly two-thirds of the region's sheltering programs and most of its beds. Polk County's seven programs hold about 4.4% of regional capacity, and no day or resource center operates anywhere in the county. Across Polk County, there are 84 individual beds and 3 household units available for 357 people who are experiencing homelessness. Sixty-six percent

of the people counted in Polk County were unsheltered. Rural participants described being directed to Salem for services, and they described services and infrastructure absent from their communities altogether, including no laundromat in Falls City, no day space in Stayton, and a warming center that opens only after three consecutive days at or below 34 degrees if volunteers can be found.

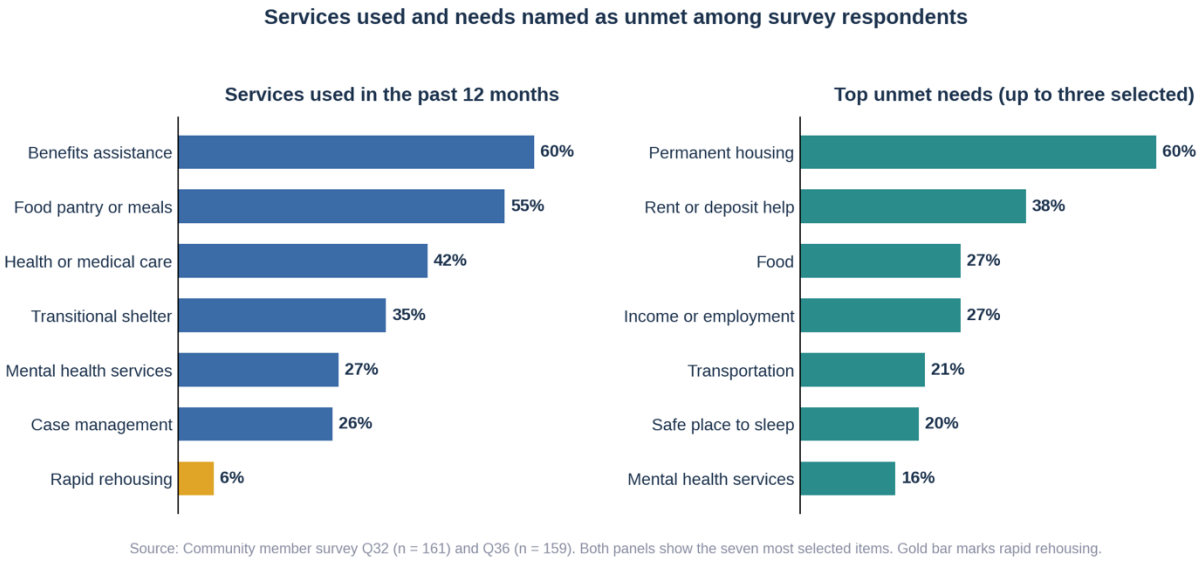

Figure 1. Services respondents used in the past 12 months and needs they named as unmet. The left panel shows the six most used services plus rapid rehousing, marked in gold. The right panel shows the seven most named unmet needs. While permanent housing was cited as the top unmet need, access to services to support permanent housing, rapid rehousing, was only accessed by 6% of the respondents.

Findings by evaluation question

Table 3. Findings by evaluation question

Evaluation question	What the evidence shows
1. Who is experiencing homelessness	The Point-in-Time count identified 2,135 people across the two counties, 953 of them unsheltered. About one in five, 419 people, were in families with children, and the count also identified 108 veterans and 124 people over age 64. Survey respondents and listening session participants describe a population that is largely local and long-term or recurrent. Forty-two percent of survey respondents grew up in the area or had lived here for more than ten years. Of respondents who had moved, 71% came from elsewhere in Marion or Polk County or from another Oregon county. Three-quarters of survey respondents reported a long-term physical or mental health condition. Listening session participants concentrated at both ends of adulthood, young adults who left family and child-serving systems and older adults on fixed incomes. Nearly two-thirds of respondents report an earned income of under $500 per month.
2. Why people become homeless	Housing loss most often followed several events at once. Could not afford rent was the most selected contributing factor at 38%, with mental health, family breakdown, and job loss each near 30%. Providers most often

Evaluation question	What the evidence shows
	reported inability to afford rent, at 87%. Release from jail, hospitals, and foster care appeared among the circumstances providers see most, with few formal connections to those institutions.
3. What services exist	Forty-four sheltering programs run by 18 organizations and concentrated in Salem. Capacity is largest at the emergency and low-barrier end and smaller in transitional housing. Dedicated capacity is smallest for minors, young adults, and survivors of domestic violence. In Polk County, shelter beds equaled 22% of the people counted in 2025, compared with 89% in Marion County. The standalone landscape scan report documents the full inventory.
4. What the gaps are	Permanent housing and rent or deposit assistance were the most named unmet needs. The landscape scan documented gaps in transitional housing, family walk-in access, beds for young adults and survivors of domestic violence, culturally specific and language-accessible services, and capacity in Polk County relative to the people counted here.
5. What the barriers are	Barrers to reaching services and shelter were, in order, not knowing what exists, waitlists, transportation, and program rules, including pet and partner exclusions. Barriers to employment and housing included the cost of replacing identification, criminal and credit records, and receiving notifications by mail only.
6. How well services are meeting needs	The services used most address daily needs. The needs most often named as unmet concern leaving homelessness. Rapid rehousing reached 6% of respondents in the past year. Respondents credited relationships with specific people about as often as services, and the harms they named most often were program rules.
7. Populations needing targeted approaches	Families with children, youth and young adults, older adults, people with disabilities and behavioral health needs, survivors of domestic violence, justice-involved individuals, Latinx and farmworker communities, rural residents, and people excluded by pet and sobriety rules each face distinct circumstances documented in this report.
8. What to do	Fund basic dignity infrastructure, reduce the cost and difficulty of replacing state identification, fix mail-only contact, create a flexible regional housing and diversion fund, repair Coordinated Entry's assessment and communication gaps, expand housing supply priced to actual incomes, and build the shared information layer the system lacks. The recommendations section presents the full set with supporting evidence.

1. Introduction

1.1 Why This Assessment, and Why Now

In 2025, the Point-in-Time Count identified 2,135 people experiencing homelessness across Marion and Polk Counties[2]. This represents an increase of more than 480 people since 2023, when the count identified 1,683 people. Nearly half of those counted, 47%, reported that this was the first time in their lives they had lost housing. At the same time, 618 people, more than one in four, met the federal definition of chronic homelessness[3], and had experienced homelessness for more than three years. These two figures describe two different realities unfolding at once: a significant wave of people entering homelessness for the first time, and a system that has not kept pace in returning people to housing once they lose it.

The conditions producing both are visible in the regional housing market. Rental vacancy across the two counties sits at roughly 4%, and about one in four renter households is severely rent burdened, paying more than half of household income toward housing. In some communities the rate is higher still, reaching 31% in Dallas and 33%in Monmouth. In a housing market with these conditions, a single missed paycheck, a health crisis, or the end of a relationship can move a household from housed to unhoused in a matter of weeks.

Point-in-Time counts and Housing Inventory Counts are designed to measure how many people are homeless on a single night and how many beds exist to serve them. They are not designed to explain how people got there, what they tried before they lost housing, what happened when they sought help, which parts of the response system are functioning and which are not, or what people believe would have changed the outcome. Those questions require asking people directly.

The Mid-Willamette Valley Community Action Agency (MWVCAA) commissioned this assessment to answer those questions. MWVCAA engaged Woodson Insights Research + Evaluation (WIRE) to conduct a mixed-methods needs assessment across both counties, combining a verified inventory of the sheltering services, surveys of community members experiencing homelessness and of the providers who serve them, and listening sessions in communities across the region. The purpose was not to produce another count but instead to understand the lived experiences of community members experiencing homelessness and the service providers that support them in accessing services.

1.2 The Evaluation Questions

Eight evaluation questions guided the design and implementation of this assessment. The questions begin with the foundation: who is experiencing homelessness in Marion and Polk Counties, and what factors contribute to people losing their housing. From there they turn to the response, asking what services exist, where the gaps are, what barriers keep people from

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[2] Mid-Willamette Valley Homeless Alliance, *2025 Point-in-Time Count Summary Report*, April 29, 2025

[3] A person with a disability who has been unsheltered or in emergency shelter for at least 12 months, continuously or across four or more episodes in three years. U.S. Department of Housing and Urban Development, 24 CFR § 578.3

reaching help, and how well current services are meeting people's needs. The questions also focus on which populations carry unique needs that a one-size-fits-all approach would miss. Lastly, these guiding evaluation questions look ahead, asking what high-impact, actionable steps the region can take to improve services and outcomes. Together, the questions move from understanding the problem, to examining the response, to charting what comes next.

Table 4. Evaluation questions that guided the assessment

Evaluation questions
1. Who is experiencing homelessness in Marion and Polk Counties, including demographics, household composition, and geographic distribution?
2. Why are people becoming homeless? What are the root causes and contributing factors?
3. What services currently exist to address homelessness, including inventory, coverage, and capacity?
4. What are the gaps in services, including unmet needs, geographic coverage, and populations underserved?
5. What barriers exist to accessing services or achieving housing stability?
6. How well are current services meeting the needs of people experiencing homelessness?
7. What populations have unique needs requiring targeted approaches?
8. What high-impact, actionable recommendations can improve services and outcomes?

1.3 Guiding Framework

Two frameworks guided this assessment. Culturally Responsive and Equitable Evaluation (CREE) holds that people with lived experience of homelessness are experts on their own circumstances, and it shaped who was invited to speak, how questions were asked, and whose interpretations carried weight in the analysis. Data to Dialogue holds that an assessment should be built around the decisions it will inform, and that delivering findings is part of the research rather than the end of it.

Culturally Responsive and Equitable Evaluation. CREE holds that people with lived experience of a problem hold knowledge that cannot be obtained from administrative data or provider reports alone, and that research relationships carry power dynamics that must be addressed through design rather than disclaimed in a limitations section. In practice this meant compensating participants, holding sessions in trusted community settings, offering multiple ways to participate, asking about strengths and survival strategies rather than only deficits and barriers, and disaggregating findings by identity and geography. It also meant asking whether the system has caused harm, a question most needs assessments do not ask.

Data to Dialogue. WIRE designs assessments backward from decisions rather than forward from available data. Every item in every instrument in this study exists because it informs choices providers, community partners, and policy makers will make. The methodology also treats the delivery of findings as part of the research rather than the end of it, which is why this

report is accompanied by a facilitated sensemaking session in which community members, providers, and partners work through the implications of the findings together, testing and sharpening the recommendations this report sets out.

The two frameworks work in sequence. CREE ensured the evidence was gathered with the community rather than extracted from it. Data to Dialogue ensures the evidence is used to develop actionable insights and strategic recommendations to improve the conditions of the community.

1.4 How to Read This Report

The report moves from context to evidence to action. Section 2 details the methodology, describing each data source and how the components fit together. Sections 3 and 4 set the stage, describing the region and the services that currently exist within it. Sections 5 through 8 turn to the people at the center of this assessment: who is experiencing homelessness, the pathways that led them there, and what happened when housing was lost. Sections 9 through 12 examine the service system from both sides of the counter, first through the experiences of people trying to use it, then through the accounts of the organizations operating it. Sections 13 bring the threads together, addressing populations with distinct needs, where provider and community accounts align or diverge, and the gaps that emerge from the full body of evidence. Section 14 translates the findings into recommendations. Every section closes with a key takeaways box summarizing its central findings.

Findings from the landscape scan are woven throughout this report and summarized in Section 3; the scan is documented in full in its own standalone report, Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026), which readers should consult for the complete program-level inventory, maps, and appendices.

Quotations from listening sessions and open-ended survey responses appear throughout. They have been lightly edited for readability only, and identifying details have been removed. Every quotation reflects something a participant actually said or wrote.

2. Methodology

2.1 Design Overview

This assessment used a mixed-methods design, which combined qualitative and quantitative data. Quantitative and qualitative data were collected in overlapping periods and analyzed in parallel, then integrated during interpretation. The design pairs two survey instruments, one administered to community members experiencing homelessness or housing instability and one administered to service providers. Focus group listening sessions provided depth and context that survey items cannot capture, and the landscape scan provided an independent, verified account of what sheltering services actually exist. Secondary data from the PIT counts were analyzed as well to understand the regional context regarding housing instability.

Table 5. Data sources, descriptions, and collection periods

Data source	Description	Period
Landscape scan and shelter inventory	A verified inventory of the region's sheltering landscape, documenting capacity, eligibility rules, access requirements, and geographic distribution across 44 programs operated by 17 organizations.	March to May 2026
Community member survey	A survey of people experiencing or recently exiting homelessness, capturing pathways into homelessness, service experiences, barriers, and unmet needs. The survey yielded 161 complete responses.	May 12 to August 12, 2026
Service provider survey	A survey of staff at homeless-serving organizations, capturing capacity constraints, program requirements, referral practices, and perceived system gaps. The survey drew 90 respondents across organizations.	May 12 to August 12, 2026
Community listening sessions	Facilitated group discussions held in trusted community settings across the region, centering the accounts of people with lived experience of homelessness. WIRE held 8 sessions, including 7 sessions with 56 community members with lived experience with homelessness and 1 session with 9 service providers.	May to August 2026
Secondary data	Existing regional data used for context and triangulation, including Point-in-Time counts, and the Housing Inventory Count.	2023 to 2026

Throughout the report, findings from all methods are woven together by topic, so that each section presents survey, listening session, and landscape scan evidence side by side rather than in separate silos.

2.2 Landscape Scan and Shelter Inventory

WIRE conducted a landscape scan of sheltering services for people experiencing homelessness in Marion and Polk Counties from March through May 2026. The scan was

organized around a structured shelter inventory instrument that captured each program's organization and populations served, shelter type, capacity, operating hours, eligibility and access requirements, outreach methods, and funding (for the full instrument, see Appendix E). The scan covers sheltering programs specifically, defined as the emergency, low-barrier, warming and cooling, transitional, permanent supportive, recovery-focused, day-center, and rapid-rehousing programs that make up the region's sheltering continuum. It does not inventory the broader network of food, health, employment, and other non-housing services available to people experiencing homelessness.

Every program's information was verified through a tiered process. Each entry began with internet research, followed where possible by a brief confirmation call with staff, then a more detailed conversation with program leadership by phone or email. In addition, all organizations included in the landscape scan were invited to participate in a feedback session with MWVCAA staff to review a draft of the landscape scan. As a final step, WIRE sent each program a written summary of its recorded details for confirmation and approval before publication. Not every program completed every tier, and the depth of verification varied with each provider's availability. The standalone landscape scan report documents the verification status of every program.

This ground-truthing is a deliberate methodological choice. Published service directories in most regions contain listings that are outdated, duplicated, or describe capacity that no longer exists, and a directory that has not been verified against the programs it describes can misstate what a region actually offers. The full inventory, maps, and gap analysis appear in the standalone landscape scan report, Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026)

2.3 Community Member Survey

WIRE drafted the community member survey using the eight evaluation questions as the guide. In collaboration with MWVCAA and MWVCAA’s Housing and Homeless Services Advisory Council, we conducted two rounds of review and revised the survey instrument. The final instrument contains 50 items across eight sections covering current housing situation, homelessness history, household composition, geography and community connection, pathways into housing loss, economic circumstances, service use and barriers, service experience, and voluntary demographic questions. Extensive skip logic routed respondents past items that did not apply to them. The instrument was made available in English and Spanish. The survey was open and available for community members to complete from May 12 through August 12, 2026. The instrument appears in Appendix A.

The survey was open to adults in Marion or Polk County experiencing homelessness or housing instability, including people sleeping outside, in shelter, in transitional programs, temporarily staying with others, in motels not paid for by a program, or at imminent risk of losing housing. It was hosted on SurveyMonkey. Respondents completed the online survey and if they needed additional assistance they could call a research team member to complete the survey verbally over the phone. Respondents who completed the survey received a $20 e-gift card.

2.4 Service Provider Survey

The service provider survey was developed in parallel with the community member survey. It contained 61 questions covering organizational capacity, populations served, program requirements, harm reduction practice, Coordinated Entry, regional coordination, client barriers, data infrastructure, and open-ended questions. The survey was administered in both Spanish and English and was available for individuals to complete from May 12 through August 12, 2026. Respondents who completed the survey were offered a $15 e-gift card. The full survey appears in Appendix B.

2.5 Community Listening Sessions

WIRE facilitated eight listening sessions between May and August 2026. Seven sessions were with people currently or recently unhoused. The sessions were held in various locations in Marion and Polk County. Participants included Spanish-speaking adults, young adults aged 18 to 24, adults with hearing disabilities, adults with physical and cognitive disabilities, survivors of domestic and family violence, parents separated from their children, older adults, veterans, farmworkers, and people in recovery. All listening session participants received $75 cash.

Sessions with community members were structured around a five-station participatory mapping activity framed by the board game Chutes and Ladders. This is a trauma-informed, liberatory research practice that was developed by Geri Lynn Peak which allows participants to tell their story with dignity and authority[4]. Chutes and Ladders is a board game in which players move along a numbered path toward a finish line, climbing ladders that advance them quickly and sliding down chutes that send them backward, sometimes nearly to the start. Progress depends largely on chance, and a single square can undo many turns of forward movement. When used in the listening sessions, participants marked when their journey into homelessness began. They also identified the first event that precipitated it, plotted setbacks and supports across the intervening period, named rules and requirements that blocked them, and described what they need next and who could provide it. The station format allows everyone to contribute simultaneously, permits drawing or dictation as valid responses, and positions participants as analysts of their own journeys rather than as subjects being interviewed. Facilitated discussion followed, covering topics such as their experience seeking help, avoidance, daily navigation, identity and cultural fit, informal support networks, and what participants would say directly to decision-makers. The provider session followed a separate systems-level guide. Both guides appear in Appendices C and D.

Every session opened with a verbal consent process covering voluntariness, confidentiality, the right to skip any question or leave at any time, and group agreements. Recording occurred only with the permission of everyone present. Recorded sessions were transcribed and reviewed for accuracy; wall sheets and written packets were photographed and transcribed.

[4] Peak, G. L. *Liberatory Fun with Journey Mapping: The Journey Scroll* [eStudy 135]. American Evaluation Association

Table 6. Listening sessions by location and populations reached

Session	Location	Populations reached
Session 1	Woodburn	Latinx community and farmworkers. Session was offered in Spanish.
Session 2	Salem	Adults experiencing homelessness
Session 3	Salem	Youth and young adults 18 to 24
Session 4	Monmouth (Polk County)	Rural homelessness
Session 5	Stayton (Santiam Canyon)	Rural homelessness
Session 6	Virtual online session	Community based organizations and service providers
Session 7	Falls City (Polk County)	Rural homelessness
Session 8	Silverton	Rural homelessness

2.6 Qualitative Analysis

Qualitative data comprised transcripts and notes from eight sessions, more than 50 handwritten participant mapping packets, post-it notes, a service provider Zoom chat log, and open-ended responses from both surveys. Coding proceeded in four phases. First, an open reading of each session established its context. Second, line-level coding identified specific nameable mechanisms, a rule, a deadline, an agency, wherever participants described how something happened rather than only that it happened. Third, cross-session comparison examined where accounts converged and diverged, treating divergence as a finding rather than ignoring it. Fourth, the resulting codebook of 16 codes across six thematic families was applied to the open-ended survey responses, extending the analysis across data sources. The codebook was checked for coverage against every topic in the discussion guides to confirm that no area of inquiry went uncoded.

Written packets were analyzed as a distinct source rather than as annotation to the transcripts. Where a packet and a transcript describe the same event differently, both are reported. Quotations selected for this report represent themes that recurred across participants.

2.7 Quantitative Analysis

Survey data were exported from SurveyMonkey and cleaned before analysis. Survey responses were exported from SurveyMonkey and cleaned before analysis. Cleaning prepared the raw export for accurate counting. This included combining SurveyMonkey's two-row column headers into one row, coding write-in "Other" answers into existing categories where they matched, and flagging possible duplicate responses for review. Responses of "prefer not to answer" were kept in the data. The cleaned file contains 161 responses.

Single-response items are reported as percentages of respondents answering that item. Select-all items are reported as the percentage of respondents selecting each option, which sums to more than 100%, and the report states this wherever such an item appears. Items behind skip

logic are reported against the number of respondents who reached the item, and that base is stated. Respondents who selected "prefer not to answer" are retained in denominators and reported as their own category, because non-response to sensitive items is itself informative.[5]

2.8 Secondary Data Sources

Three categories of secondary data were used. Point-in-Time Count data from 2023, 2025, and 2026 provide trend context and a comparison point for the survey sample. Housing Inventory Count data inform the capacity analysis. Regional housing market indicators inform the context in Section 3.

One feature of the secondary data requires care. The 2026 Point-in-Time Count was sheltered people only. It did not include an unsheltered enumeration, so its totals describe a different population than the 2025 count, which enumerated both sheltered and unsheltered people. Where this report presents both, each is labeled by year and count type.

2.9 Limitations

Neither survey used probability sampling. For this population, that is a strength as much as a limitation. No sampling frame of people experiencing homelessness exists, and the methods that require one, telephone, mail, and online panels, systematically miss unsheltered residents, people without stable contact information, and people disconnected from services. Venue-based recruitment through trusted community settings reached exactly those groups, and it allowed the study to pursue inclusion deliberately by recruiting across languages, geographies, and program types rather than leaving representation to chance. The tradeoff is that the findings in this report describe the people surveyed rather than the full population, and their strength rests on convergence across methods rather than on any single sample's claim to represent the whole.

KEY TAKEAWAYS - METHODOLOGY

Five data sources are reported in this integrated report. These sources consist of the following: **a verified inventory of 44 sheltering programs, surveys of 161 community members and 90 provider staff, 8 listening sessions, and PIT and HIC data for regional context**.

Shelter inventory entries were ground-truth through a tiered verification protocol ending with program approval because published directories routinely list capacity that no longer exists.

Listening sessions positioned participants as authors of their own journeys, using a trauma-informed mapping method that reached Spanish speakers, rural residents, youth, elders, veterans, farmworkers, and survivors of violence.

[5] Community member subgroup differences were tested using the chi-square test of independence, with every reported test stating its p value and effect size as Cramér's V. Provider subgroup comparisons were tested with two-tailed Fisher exact tests, and only differences reaching $p < 0.10$ are described as differences.

Surveys were provided in English and Spanish. Respondents could complete the survey in one of three ways. They could answer by phone with a research team member, complete it online with a team member's help, or independently using the online platform. The research team increased the accessibility of the data collection process by accepting drawings or dictations during the listening sessions, so that neither English, literacy, nor internet access posed a barrier to participation.

3. Regional Context and the Sheltering Landscape

Homelessness in Marion and Polk Counties exists within a particular set of conditions. The housing market offers few vacancies and few units affordable to low-income households. The policy environment is shifting, and the region's geography concentrates services in Salem. This section describes those conditions and presents a verified list of sheltering services in the region that is working to address the issue of homelessness. The inventory covers what exists, what it costs, whom it is built to serve, and how its capacity compares to need.

3.1 Homelessness in Marion and Polk Counties

The most recent complete Point-in-Time (PIT) count, conducted in January 2025, identified 2,135 individuals experiencing homelessness across Marion and Polk Counties. At that time, the count consisted of 953 unsheltered individuals and 1,182 sheltered residents. That total is up from 1,683 homeless individuals in 2023. **At the time of the 2025 count, nearly half, 47%, were experiencing homelessness for the first time[6].**

The 2026 count was conducted differently. It counted only people staying in shelters, transitional housing, and other sheltered settings, and no unsheltered enumeration was conducted that year. The sheltered-only count recorded 953 persons. By coincidence, that is the same number as the 2025 unsheltered count.

The Point-in-Time count is also widely understood to undercount the true scale of homelessness. It misses people doubled up with friends or family, sleeping in vehicles or locations enumerators do not reach, or otherwise out of view on the night of the count. The level of need this report compares capacity against should therefore be read as a conservative floor rather than a complete picture.

[6] McDonald, A. (2025, May 5). Record number of homeless people counted in Marion, Polk counties. *Salem Reporter*. https://www.salemreporter.com/2025/05/05/record-number-of-homeless-people-counted-in-marion-polk-counties/

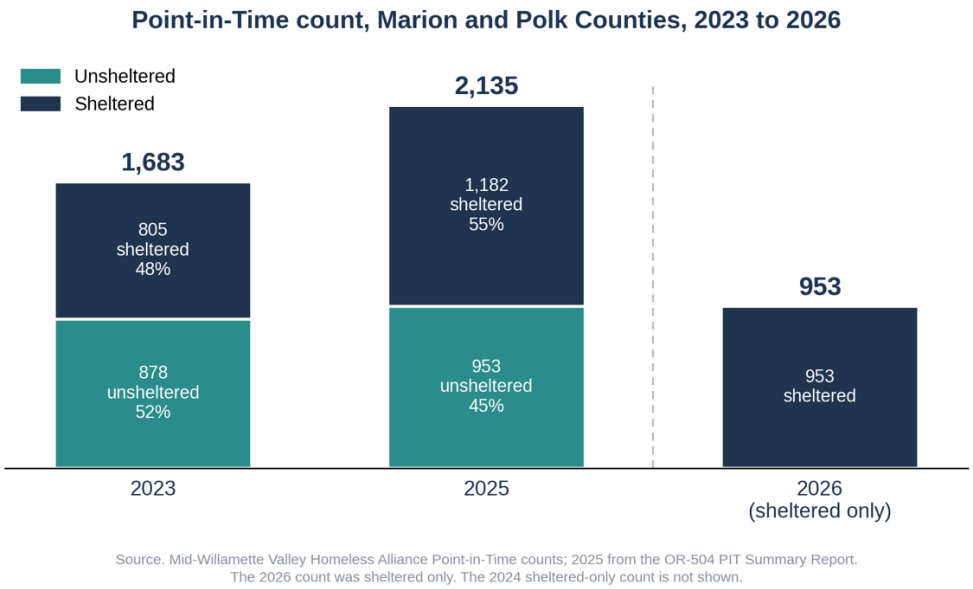

Figure 2. The Point-in-Time trend for 2023, 2025 and 2026. The PIT count for 2026 was a sheltered-only count.

3.2 Housing Market Conditions

Rental vacancy in both Marion and Polk counties sits at roughly 4% . Renter households across the region face significant concerns regarding cost and affordability. **Approximately one in four renter households are severely rent burdened, spending more than half of household income on rent**[7]. Severe rent burden is most concentrated in Polk County's cities, where 33%of renter households in Monmouth, 31%in Dallas, and 28% in Independence are severely rent burdened. The supply side offers little relief. Across the state of Oregon, fewer than 30 affordable and available rental homes exist for every 100 extremely low-income renter households.[8,9]

HUD's fair market rent for a one-bedroom unit in the Salem metro area was $1,198 in fiscal year 2025, and $1,201 in fiscal year 2026, above the 2026 federal SSI payment of $994 a month. The listening sessions described the realities this market produces for people with the lowest incomes. A provider described a newly opened complex where one-bedroom units rent for $998 a month, and where more than 260 families arrived within half an hour on sign-up day. Participants described three-times-rent income requirements, vouchers capped below asking rent with no ability to pay the difference, and rents that doubled over the course of their tenancy.

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[7] Oregon Department of Land Conservation and Development. (2022). *2022 severe rent burden in Oregon (2020 ACS)*. https://www.oregon.gov/lcd/UP/Documents/Annual_Severe_Rent_Burden_Announcement.pdf
[8] National Low Income Housing Coalition. (2026). *The gap: A shortage of affordable rental homes: Oregon*. https://reports.nlihc.org/gap/state/OR
[9] U.S. Census Bureau. (2025). *Selected housing characteristics* (American Community Survey 5-Year Estimates Data Profiles, 2020–2024, Table DP04) [Data set]. U.S. Department of Commerce. https://data.census.gov/table/ACSDP5Y2024.DP04

> *"When I moved in it [the rent] was $895, and when I moved out it [the rent] was increased to $1,800. So I couldn't afford it no more. So here I am."*
>
> Listening session participant, Silverton

Nearly two-thirds of community survey respondents were living on an income of less than $500 per month, including 36% with no income at all. At those incomes levels, no market-rate unit in the region seems affordable. This highlights the fact that there is a supply-and-affordability gap that exists throughout the region.

3.3 Policy Environment

State policy shapes the region's response in three areas: emergency response funding, the laws governing enforcement, and behavioral health financing.

Oregon has operated under a declared homelessness state of emergency since January 2023, and the associated investment has expanded the region's shelter capacity. Governor Kotek extended the declaration for a third time on January 2026 through Executive Order 26-01, which runs through January 2027. While earlier orders targeted shelter capacity broadly, Executive Order 26-01 centers the intersection of homelessness, mental health, and addiction, directing approximately $20 million toward permanent supportive housing and behavioral health programs.[10]

In addition, **two 2021 statutes set the terms under which local governments may regulate and remove unsheltered encampments. House Bill 3115** (ORS 195.530), which has been operative since July 1, 2023, requires that any city or county law regulating sitting, lying, sleeping, or keeping warm and dry outdoors on public property be objectively reasonable as to time, place, and manner with regard to persons experiencing homelessness.[11] This bill also gives a person experiencing homelessness a way to challenge ordinances that fall short of that standard.

House Bill 3124 (ORS 195.505) sets the procedures local governments must follow when removing people from an established camping site.[12] With this bill, officials are required to give a 72-hour notice and that notice must be provided in English and Spanish at all identifiable entrances. Once the 72-hour notice is posted, law enforcement must tell the local agency that provides social services to people experiencing homelessness where the notice was posted. Another stipulation in the bill requires the personal property of those who were removed from the homeless encampment must be stored for at least 30 days within the community from which it was taken. Items with no apparent value or utility, or in an insanitary condition may be discarded immediately upon removal of the homeless individual from the camping site.

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[10] Office of the Governor, State of Oregon. (2026, January 9). *Governor Kotek issues executive order to extend homelessness emergency*. https://apps.oregon.gov/oregon-newsroom/OR/GOV/Posts/Post/governor-kotek-issues-executive-order-to-extend-homelessness-emergency

[11] H.B. 3115, 81st Leg. Assemb., Reg. Sess. (Or. 2021). https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3115/Enrolled

[12] H.B. 3124, 81st Leg. Assemb., Reg. Sess. (Or. 2021). https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3124

Weapons, controlled substances other than prescription medication and items that appear to be either stolen or evidence of a crime shall be given to or retained by law enforcement officials. Together these statutes set the minimum standard for how removals must be conducted in the region.

Ballot Measure 110, passed by Oregon voters in 2020, funds recovery-focused capacity in the region, including two recovery-focused housing programs.[13] Now administered by the Oregon Health Authority as the Behavioral Health Resource Network Program, it has been restructured in four legislative sessions since passage. Providers described the effects of those funding changes, including a peer-run recovery center that lost 78% of its funding and reduced their operations from seven days a week to five hours a day, five days a week.

These policies shape the funding structure highlighted in the Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026). According to the landscape scan, 75% of sheltering programs list the State of Oregon as a primary funding source, and 12 programs are funded by the state alone, with minimal city and county investment. The implication of this finding is that a budget reduction or policy shift could affect the majority of the system's largest programs at once, with little diversification to absorb the loss.

3.4 Sheltering Capacity

In June 2026, MWVCAA commissioned a landscape scan, which is documented in full in the standalone report, Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026). Readers needing the complete program-level inventory, verification records, maps, and capacity appendices should consult that report.

The Marion and Polk region is home to 44 sheltering programs for people experiencing homelessness and is operated by 17 independent organizations. A handful of operators carry most of the load. MWVCAA operates 15 programs, accounting for 34% of all sheltering programs; Church at the Park operates six; and The Confederated Tribes of Grand Ronde operates three verified shelters, an important Tribal contribution to regional capacity. Together these organizations operate more than half of all sheltering programs in the region.

The continuum of sheltering services spans emergency shelter, low-barrier shelter, warming and cooling sites, transitional housing, permanent supportive housing, recovery-focused shelter, day centers, and rapid rehousing, with many programs self-identifying as more than one type. Program categories should therefore be read as descriptive rather than mutually exclusive.

On a typical night the system offers 1,421 individual beds and 230 family units. Family-serving programs report capacity in households rather than beds; converting at a conservative three individuals per household, typical combined capacity is approximately 2,111 sleeping spaces across 38 programs. During inclement weather an additional 247 warming beds across five programs bring combined capacity to approximately 2,358.

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[13] Oregon Health Authority. (n.d.). *Behavioral Health Resource Network (BHRN) Program*. https://www.oregon.gov/oha/hsd/amh/pages/measure110.aspx

Capacity is concentrated at the edges of the continuum. The largest single pool of individual beds is low-barrier, with 311 beds across the five ARCHES network programs, and a further 529 beds are categorized as emergency shelter across 11 programs that vary widely in size, philosophy, and eligibility. At the long-term end, permanent supportive housing accounts for 65 individual beds with very low turnover. Permanent supportive housing is designed as a long-term home. Most of these programs reported unlimited lengths of stay and run at or near full occupancy, so a unit opens only when a resident leaves. The transitional middle is comparatively thin: transitional housing accounts for 295 beds and 112 households combined, spread across 15 mostly small, population-specific programs. **For a person ready to leave emergency shelter for something more stable, the pipeline forward is narrow, which means people stay in emergency and low-barrier beds longer and those beds turn over more slowly.**

Table 7. Dedicated capacity and the 2025 Point-in-Time count by population among sheltering programs

Population	Programs	Beds	% of beds	Household units	% of units	Sleeping spaces (beds plus units × 3)	People counted, 2025 PIT	% of PIT	Spaces short of or over the count
Adults only	12	683	48%	0	0%	683	1,700	80%	1,017 short
Adults with children	17	453	32%	211	92%	1,086	419	20%	667 over
Survivors of domestic violence	2	130	9%	0	0%	130	420	20%	290 short
Veterans	3	119	8%	0	0%	119	108	5%	11 over
Youth, ages 11 to 17	2	20	1%	0	0%	20	16	1%	4 over
Young adults, ages 18 to 24	2	16	1%	19	8%	73	88	4%	15 short
Total	**38**	**1,421**	**100%**	**230**	**100%**	2,111	2,135		24 short

Note. Capacity from the landscape scan, Table 7. Beds are non-inclement individual sleeping spaces. Household units are converted at three people per unit, the convention used elsewhere in this report, to give sleeping spaces. Day centers and warming-only programs carry no year-round beds and are excluded, which brings 44 programs to 38. People counted from the 2025 HDX summary for OR-504 (count date January 22, 2025). The last column is sleeping spaces minus people counted. PIT groups overlap. Veterans and survivors of domestic violence are also counted among adults, so the rows do not sum and only the total is additive. The domestic violence figure is an optional HUD field that records adult survivors. Percentages are of 2,135 and rounded to whole numbers.

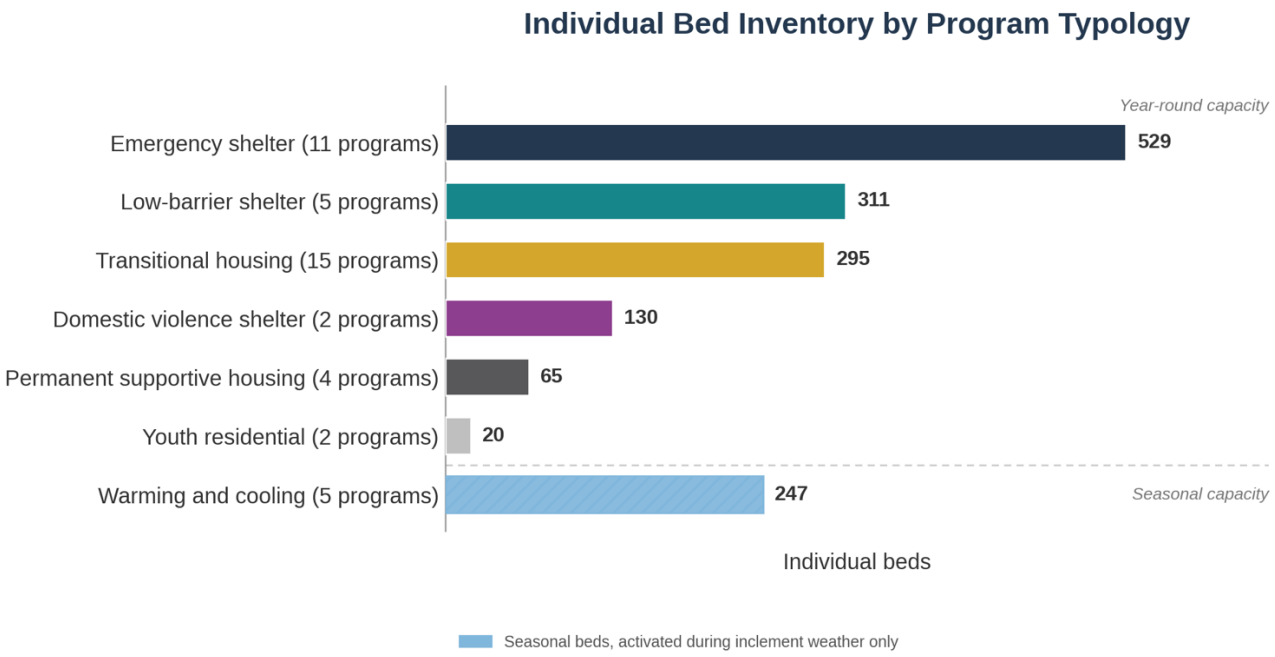

Figure 3. Individual sleeping spaces by program typology. Household units are reported separately and are not included here (1 household unit does not equal 1 bed). Because programs self-identify with more than one shelter type, these categories overlap and are descriptive rather than additive. Bars do not sum to the region's total bed capacity. Warming and cooling beds are activated during inclement weather only and are shown separately from year-round capacity. Transitional housing reflects all programs whose shelter type combination includes transitional housing. Source: Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis, Finding 6.

3.5 Verification Findings and Reporting Gaps

The process of confirming each program's details revealed patterns of its own. Different contacts within the same organization sometimes provided different capacity figures, which can be interpreted not as an error but as evidence that these organizations continually adapt to changing needs. Bed counts and availability are a moving target rather than fixed values. Reporting was also uneven on key metrics. Average operating cost per bed was reported by only 15 of 44 programs and reflected different underlying definitions, unique individuals served annually was reported by 28 of 44, and five programs did not report operating hours at all. Two Tribal transitional living centers in each of two Tribal organizations, four total, were excluded from the count because bed data could not be verified.

Cost data were reported unevenly, but what was reported is still informative. Fifteen of 44 programs reported an average operating cost per bed per night, ranging from $12 to $242 with a median of $43. The spread reflects different service models as well as different accounting definitions: a volunteer-staffed seasonal warming shelter and a staffed program with behavioral health supports are not producing the same product. Even with those caveats, a median nightly cost of $43 per bed is a useful reference point for regional planning. This figure sits below the routinely cited costs of institutional settings such as emergency departments and jail beds, where unsheltered people often spend time instead. The highest costs were in small programs

serving youth and survivors of domestic violence. These figures describe the reporting programs only. They are not an estimate of the system's total or average cost.

3.6 Geographic Coverage

Sheltering capacity is concentrated in Salem. The city holds roughly two thirds of the region's 44 programs and most of its beds. Salem is also the only location where the full continuum of shelter types operates together. Polk County accounts for eight programs, offering 84 individual beds and 3 household units, roughly 6% of the region's non-inclement weather capacity. Four programs are in Dallas and three in Monmouth, leaving Independence, Falls City, and rural western Polk County without a dedicated program of their own, and no day or shelter-based resource center operates anywhere in the county. The landscape scan found no shelter-affiliated day center in Polk County. The county has non-shelter resource sites including the Polk Community Resource Center in Monmouth and the ROCC peer drop-in center in Dallas. These sites do not offer overnight shelter.

Capacity can also be compared with the number of people counted in each county. In the 2025 Housing Inventory Count, Polk County reported 79 shelter beds, including seasonal beds, against 357 people in the 2025 Point-in-Time count. That is 22% coverage, compared with 89% in Marion County. Sixty-six percent of the people counted in Polk County were unsheltered, compared with 41% in Marion County.

Capacity in Marion County outside Salem-Keizer area is limited. It consists of two transitional family programs in Mount Angel, a 22-bed program in Silverton, 20 year-round beds in Woodburn, and a seasonal warming site in Mill City. Keizer, adjacent to Salem, hosts the 80-bed Simonka Place. The system's large-capacity resources, including the ARCHES low-barrier network, bilingual staffing, behavioral health services, and around-the-clock access, are located in Salem.

Reaching that core capacity generally requires travel to Salem. For a person in rural Polk County or eastern Marion County the distance is itself a condition of access. Since dedicated capacity outside Salem is small, a single waitlist, closure, or eligibility mismatch can leave a community without a nearby option. Entry pathways compound the pattern in Polk County, where most capacity is not walk-in: two programs require an online application, two accept referrals only, and one maintains a waitlist by default. Three programs report no waitlist, but none functions as a general-population walk-in option.

3.7 Physical Conditions and Operating Access

The physical form of the inventory constrains who can use the various facilities. About 30% of beds are bunks, and roughly a third are in congregate settings. These configurations exclude many older adults and people with mobility disabilities. Top bunks require climbing, which may not be safe for older adults, pregnant people, or people with balance or mobility limitations. Congregate rooms offer little privacy or control over noise and light. Only 25 of 44 programs operate 24 hours a day. The remainder close for some or all of the day, which is why day centers and, in their absence, libraries and parks are among the places people experiencing homelessness most frequently spend their days. Only 15 of 44 programs, about a third, accept

true walk-ins. The rest require referrals, appointments, online forms, or waitlist placement. This converts shelter access into an administrative process for this population. Physical accessibility is affirmatively reported at only 12 programs and unreported at 32, so the region cannot currently state how much of its inventory a wheelchair user can enter.

3.8 Who the System Is Built to Serve

Almost half of all individual beds, 48%, are designated for adults only. The 2025 Point-in-Time count identified 1,700 adults in adult-only households. This capacity is anchored by a small number of large Salem programs. Families are counted primarily in household units, and 92% of household units are dedicated to adults with children. The count identified 122 family households, or 419 people. Only five family units were open at the time of reporting, the thinnest point of open access in the system. Dedicated capacity for minors totals 20 beds across two ten-bed programs, one in Salem and one in Monmouth. The count identified 16 unaccompanied minors, a group single-night counts are likely to undercount. Young adults ages 18 to 24 have 38 beds in dedicated or near-dedicated programs, and the count identified 88n young adults experiencing homelessness. Survivors of domestic violence are served by two dedicated programs totaling 130 beds, one in each county. The count identified 420 adult survivors, a measure that includes survivors who are not seeking domestic violence shelter. Veterans have 119 dedicated beds, and the count identified 108 veterans. For minors, young adults, and survivors, the small number of providers means a single closure, waitlist, or geographic mismatch can leave a person with no dedicated option within reach.

The system's default position towards housing and sheltering is inclusion rather than specialization. Forty-one of 44 programs report serving all races and ethnicities. Programs operate under federal fair housing and civil rights rules that generally bar limiting admission by race, color, national origin, or other protected characteristics. Within those rules, programs can build culturally specific practice through outreach, staffing, language access, and program design. Serving everyone is not the same as being equipped to serve a particular community well. Culturally specific capacity therefore usually means staffing, language, outreach, and practices suited to a community, not restricted eligibility. Only three programs are culturally specific, all serving Tribal members through The Confederated Tribes of Grand Ronde: Warriors of Hope, Village One, and Village Two. One additional program reported Black or African American residents as a primary population it serves. No program indicates that it specifically serves the region’s Latine community, even though the 2025 PIT counts identified Latine residents as disproportionately unsheltered. No program is designated for LGBTQIA+ residents. Language capacity beyond Spanish thins sharply, with Russian at four programs, sign language at three, Marshallese at two, and Chuukese at none.

3.9 Capacity Compared to Estimated Need

At the system's typical capacity of roughly 2,111 combined sleeping spaces, shelter comes up about 24 beds short of the 2,135 people identified in the 2025 Point-in-Time count. That gap closes on paper during inclement weather, when 247 seasonal warming beds bring combined capacity to roughly 2,358. But that near-parity is misleading. The PIT count undercounts actual homelessness, so need is higher than the comparison target. Total bed counts also do not

account for eligibility restrictions, geographic access, real-time availability, or program rules, so usable capacity is lower than the inventory figure. For instance, a women-only or veterans-only bed is not available to someone who does not qualify. Similarly, a bed in Salem does little for someone in rural Polk County without transportation. A bed counted in the inventory may be occupied, waitlisted, or offline on any given night.

The occupancy data confirm how little slack exists. Twenty-eight of 44 programs report maintaining a waitlist. Permanent supportive housing runs at or near 100% occupancy with very low turnover. Transitional housing is nearly as full with 9 of 10 programs at capacity, and 10 of 15 emergency shelters are at capacity. When the back of the system does not move, the front cannot either. The gap between need and usable capacity is therefore wider than a direct comparison of total beds to total need would suggest. The following sections examine the rules, pathways, and information failures that widen it further.

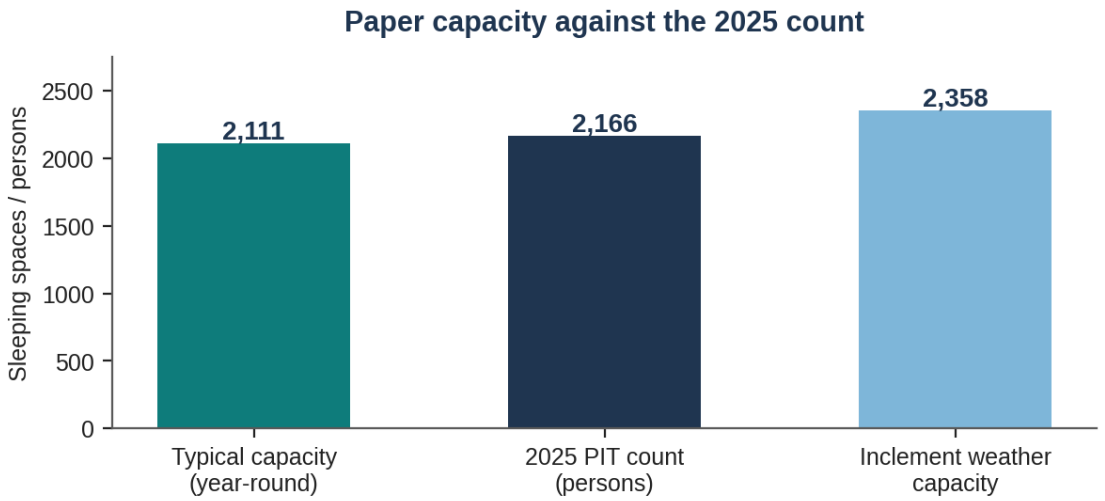

Figure 4. Paper capacity against the 2025 count. Near parity in the totals coexists with waitlists at 64% of programs and full occupancy through the back of the continuum.

KEY TAKEAWAYS – REGIONAL CONTEXT AND THE SHELTERING LANDSCAPE

- **The 2025 Point -in-Time count identified 2,135 people, up from 1,683 in 2023. Forty-seven percent were experiencing homelessness for the first time.** The sheltered count fell from 1,182 in January 2025 to 953 in January 2026. A sheltered count reflects the beds occupied on the count night, so the change can reflect a change in capacity and occupancy as well as need. The 2026 count did not include unsheltered people.
- Housing costs in the region exceed the incomes many people have. HUD's fair market rent for a one-bedroom unit in the Salem metro area was $1,198 in fiscal year 2025 and $1,201 in the

2026 fiscal year.[14] The federal SSI payment for an individual in 2026 is $994 per month. Among survey respondents reporting an income amount, 64% lived on less than $500 per month

- **44 sheltering programs run by 17 organizations provide real scale**, with MWVCAA operating a third of all programs and state funding underwriting **75%** of them, leaving the region exposed to any single funder's shift.
- Typical capacity of roughly 2,111 sleeping spaces sits about 24 beds short of the 2025 PIT count, but near-parity on paper is misleading. The count underscores the need and the inventory overstates what is actually usable.
- Capacity concentrates at the edges of the continuum. Emergency and low-barrier beds are the system's strength. The transitional middle that moves people toward stability is thin and youth and family walk-in capacity are the thinnest points of all.
- This sheltering ecosystem is concentrated in Salem. Polk County holds 4.4% of capacity, and specialized services are almost entirely Salem-based, Openness is not specialization. Nearly every program serves all races and ethnicities, yet culturally specific capacity is limited to three Tribal programs. No program serves the Latine community specifically.
- The region has built real capacity. Forty-four programs across 17 organizations provide roughly 2,111 sleeping spaces on a typical night. Low-barrier shelter anchors the system with 311 beds, and 25 programs operate around the clock. During inclement weather, 247 seasonal beds lift capacity beyond the count of homeless individuals.
- Cost per bed cannot yet be measured across the system. Fifteen of 44 programs reported it, using different definitions.

[14] U.S. Department of Housing and Urban Development, Office of Policy Development and Research, "FY 2026 Fair Market Rents, Salem, OR MSA," HUD USER, effective October 1, 2025, https://www.huduser.gov/portal/datasets/fmr.html.

4. Who Is Experiencing Homelessness

4.1 Where People Were Counted

The 2025 Point-in-Time count describes where people were on one night. Statewide estimates from Portland State University divide the count by county.[15] Marion County accounted for 1,736 people and Polk County for 357. Forty-one percent of those counted in Marion County were unsheltered, compared with 66% in Polk County. Per 1,000 residents, the rates of homelessness were 4.99 in Marion County and 4.02 in Polk County.

Polk County Family and Community Outreach conducted a separate count of rural Polk County, west of Highway 51, on the same night.[16] It counted 135 unsheltered people, 81 sheltered people, and 92 people at risk of homelessness. Dallas recorded 96 people counted as homeless or at risk, Monmouth 75, the Grand Ronde area 62, Independence 45, Falls City 24, and Willamina 6. Independence, Falls City, and Willamina recorded no sheltered people. The rural Polk unsheltered count rose from 5 in 2021 to 135 in 2025.

4.2 Current Living Situations

Survey respondents were distributed across the full spectrum of housing instability. Just under 70% were considered literally homeless:[17] 32% reside in a transitional shelter or a program, 30% unsheltered, and 8% in emergency shelter. The remainder were housed but at risk (14%), recently rehoused after a period of homelessness (11%, or doubled up (4%). Among respondents sleeping outside, encampments and tent communities were the most common location, followed by streets, doorways, and parks, and then vehicles.

Unsheltered homelessness in this sample is not transient. Of the 43 respondents who selected sleeping outside, 12 had been in the same location for more than a year and an additional eight respondents had been in the same location for at least seven months. Across the full sample, 38% of the survey respondents had been in their current housing situation for more than a year. **For a substantial share, homelessness or housing instability is not a brief disruption but a prolonged condition.**

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[15] Cho, M., Greene, J., Spurbeck, F. H., & Zapata, M. (2026). *2025 Oregon statewide homelessness estimates*. Portland State University Homelessness Research & Action Collaborative. https://pdxscholar.library.pdx.edu/hrac_pub/53/

[16] Polk County Family and Community Outreach, "Rural Polk County 2025 Point in Time Count Data," Polk County, Oregon, count conducted January 22, 2025, https://www.polkcountyor.gov/1162/Point-In-Time-PIT-Count

[17] U.S. Department of Housing and Urban Development. (2012). *Criteria and recordkeeping requirements for definition of homeless*. HUD Exchange. https://www.hudexchange.info/resource/1974/criteria-and-recordkeeping-requirements-for-definition-of-homeless/

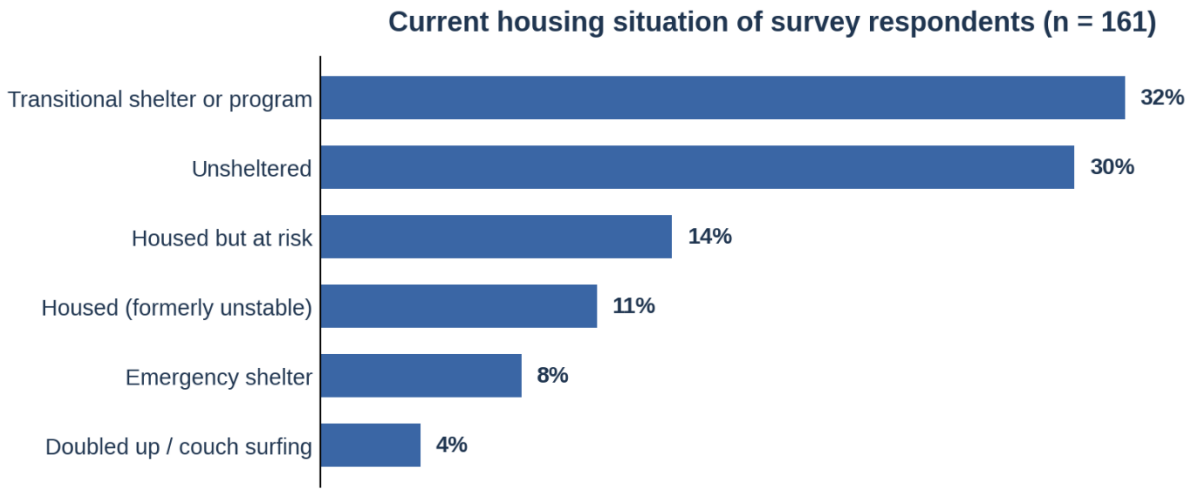


Figure 5. Where respondents were living at the time of the survey.

The survey was distributed largely through service providers and shelter sites, so people connected to services may be overrepresented. Forty percent of respondents were in a shelter or program when they responded. Among respondents who were literally homeless, 57% were sheltered, close to 55% sheltered share in the 2025 Point-in-Time count.

4.3 First-Time and Recurrent Homelessness

In the community member survey, **two-thirds of respondents who answered had experienced homelessness or housing instability before the current episode**. Among the 103 respondents with a prior history, two-thirds had spent 12 months or more homeless within the past three years, and just under a third had experienced four or more separate episodes in that window. Repeated episodes and long duration are related but distinct. Of the 68 respondents who experienced homeless for 12 or more months in three years, 31 had four or more separate episodes of homelessness. This is an indication of a cyclical pattern of gaining and losing housing. In addition, the other 37 respondents experienced fewer episodes of greater length. Both patterns describe homelessness that has persisted, but they imply different responses. Together, these findings indicate that for many people currently experiencing homelessness in the region, the current episode is not their first, and prior episodes either recurred or ran long.

The listening session data shows a similar pattern. **Sixty-nine percent of session participants reported more than a year of homelessness in total**. Only four participants reported experiencing homeless for less than three months. The difference from the PIT's first-time figure is not a contradiction. The count captures everyone on one night, while this assessment reached people connected to services and sessions, who skew long-term. However, it does mean that the population the response system interacts with day to day is substantially a recurrent, long-duration population. As shown later in this report, the longer someone has been homeless, the more critically they tend to describe the system.

4.4 Household Composition

Household composition describes who is navigating homelessness together. The community member survey asked two questions about household composition: how many adults share the respondent's household, and whether children under 18 are in their care. A majority of respondents reported single-person households. Among respondents who were parents of minor children, some had their children with them and others did not. In the 2025 Point-in-Time count, 419 people, about one in five of those counted, were in households with at least one adult and one child. These 122 households included 246 children under 18, and 40 of them were unsheltered. Among community member survey respondents, 25 of 161, or 16%, had children under 18 with them.

The listening session data, described below, add context to this pattern of family separation.

Table 8. Adults in household and children under 18 in care among survey respondents

Adults in household	n	%		Children under 18 in your care	n	%
Just me	89	55%		No	118	73%
2 adults	43	27%		Yes, children with me now	25	16%
5 or more people	16	10%		Yes, but not with me right now	15	9%
3 to 4 adults	13	8%		Prefer not to answer	3	2%

The middle rows of the table's right-hand column show the family separation finding. Fifty-five percent of survey respondents were single-person households. Of the 40 respondents who were parents of minor children, 25 had their children with them and 15 were separated from their children. During the listening session, one mother reported she had been separated from an autistic son because no shelter could accommodate him.

Four respondents were pregnant. Forty-three percent of respondents had a pet. Ownership differed sharply by housing situation: 60% of unsheltered respondents had a pet, compared with 17% of sheltered respondents. Later in this report, we examine one likely reason for this difference, shelter rules that exclude animals, and what pet owners described giving up to keep them.

4.5 Demographics

This section describes who participated in the community needs assessment, drawing on the survey's demographic items and the listening session sign-in data. The survey sample skews toward working-age adults, with 45% aged 25 to 44 and 33%aged 45 to 64. Women outnumbered men, 54% to 42% and 11 respondents identified as transgender, non-binary, gender non-conforming, or self-described. Just over 70% of respondents who reported a race or ethnicity identified as White alone. Hispanic or Latino/a/e/x respondents were the largest group

among respondents of color at 13%, followed by American Indian or Alaska Native respondents at 9%. No respondent identified as Asian or Asian American. All but three respondents preferred English, and one preferred Chuukese. Six respondents identified as veterans and 22 as lesbian, gay, bisexual, queer, or another sexual orientation. The listening session participants show a different age distribution. The two largest age bands were 55 to 64 (27%) and 18 to 24 (25%). The bands in between held smaller shares of participants. Roughly six in ten participants were either under 25 or 55 and older. This distribution partly reflects session design, since one session was convened for young adults and several took place in shelters whose residents skew older. Participants in these two age groups described different pathways into homelessness. Younger participants described family expulsion at or before eighteen, and older participants described rent increases, job loss, divorce, or a medical event late in a working life.

The sessions also differed from the survey in two other respects. Session participants were majority men (52%, compared with 42% of survey respondents), and Hispanic or Latino/a/e/x participants made up 25% of session participants, roughly twice their share of the survey sample, reflecting the Spanish-language session in Woodburn.

Providers were asked whether the mix of households they serve has shifted over the past year. Thirty-six percent reported no change. Among those reporting a shift, the largest single response was an increase in older adults aged 65 and over, at 21%. This exceeded reported increases in families with children, single adults, and youth. Older adults also ranked second among the populations providers identified as falling through the cracks.

> *"We are receiving calls and serving more women who are older and became homeless for the first time ever. The rising rents and rising living expenses are beyond their capacity to make ends meet, especially with fixed incomes."*
>
> Service Provider, Survey write-in

Table 9. Age and race or ethnicity of assessment participants (N = 213)

Age band	n	%		Race and ethnicity	n	%
35 to 44	48	23%		White	161	75%
45 to 54	42	20%		Hispanic or Latino/a/e/x	35	16%
18 to 24	36	17%		American Indian or Alaska Native	19	9%
25 to 34	34	16%		Black or African American	10	5%
55 to 64	34	16%		Native Hawaiian / Pacific Islander	6	3%
65 or older	15	7%		Middle Eastern or North African	1	1%
17 or younger	4	2%		Prefer not to answer / self-describe	11	5%

Combined survey respondents and listening session participants. Age is reported for 213 participants (157 survey respondents and 56 listening session participants). Race and ethnicity is select all that apply, reported against 215 participants who answered (159 survey and 56 listening session); percentages sum to more than 100. Some listening session participants may also have completed the survey, so the two sources may include a small number of the same individuals counted twice.

4.6 Health and Disability

Three-quarters of survey respondents reported a long-term physical or mental health condition affecting daily life, including 29% reporting both a physical and a mental health condition. This was the most prevalent characteristic in the sample. Thirty-five percent of respondents named a disability or health condition as their biggest barrier to employment. Respondents with a condition were seven times more likely to report being denied services because of their identity. In the listening sessions, 43% of participants identified as a person with a disability. Conversations during the listening sessions highlighted accounts of spinal injury, stroke, traumatic brain injury, seizure disorder, deafness, wheelchair use, and disabilities participants described as invisible.

Eighty-six percent of respondents have health insurance, predominantly through the Oregon Health Plan. At the same time, 43% had visited an emergency room in the past 12 months because they could not get care elsewhere, and nine respondents had done so four or more times. **High coverage and high emergency room use appearing together suggests that barriers to care lie beyond insurance status**. In the listening sessions and open-ended responses, participants described the barriers they encountered such as the lack of appointment availability, transportation, provider unwillingness to treat, discriminatory practices and mistreatment due to being homeless, and the practical difficulty of attending scheduled care while homeless.

Table 10. Health insurance coverage among survey respondents (N = 161)

Coverage	n	%
Yes -- Oregon Health Plan (Medicaid)	125	78%
No -- I do not have health insurance	12	8%
Yes -- Medicare	8	5%
I am not sure	7	4%
Prefer not to answer	4	3%
Yes -- employer or private insurance	4	3%
Yes -- Veterans Administration (VA) coverage	1	1%

Note. Community member survey (n = 161). Respondents selected one option. Percentages are rounded to whole numbers and may not sum to 100. Counting all coverage types together, 86% of respondents reported having health insurance.

4.7 Economic Circumstances

Thirty-six percent of respondents reported not receiving any income. Among the 149 respondents who reported an income amount, 64% were living on less than $500 per month. SNAP was the most common benefit reported by community members (56%). Wages from a job followed at 24%.

Many respondents reported health conditions, and far fewer reported receiving disability benefits. Seventy-five percent of respondents who answered the item reported a long-term physical or mental health condition. Forty respondents reported being unable to work because

of disability or health. Twenty-six were receiving SSI or SSDI. In open-ended responses, several respondents described disability benefit applications that had been pending for years, including one pending since 2021.

Twenty-three respondents were working full-time, and another 22 were working part-time or in occasional or temporary jobs, while experiencing homelessness or housing instability. Having a job did not ensure a path out of homelessness. For these 45 respondents, employment and homelessness were occurring together, in a housing market where about one in four renter households is severely rent burdened and few units are affordable at low incomes.

For some respondents, employment problems came before housing loss, and for others, housing loss now stands in the way of employment. Job loss or reduced income had contributed to losing housing for 48 respondents, while 37 of those not working cited the absence of stable housing as a barrier to finding work. Forty-seven respondents were not working and looking for work, and 35 reported applying for jobs without receiving offers. Among those not working, the most common barriers were disability or health (57 respondents), transportation (43), and a criminal record (34). Fourteen respondents had used employment or job training services in the past 12 months, and 43 named income or employment support among their top three unmet needs.

> *"I work 2 jobs but somehow I do not earn enough money to pay for rent, food and bills. A voucher would help and my pay dates do not align with rent due dates."*
>
> Community Member Survey respondent

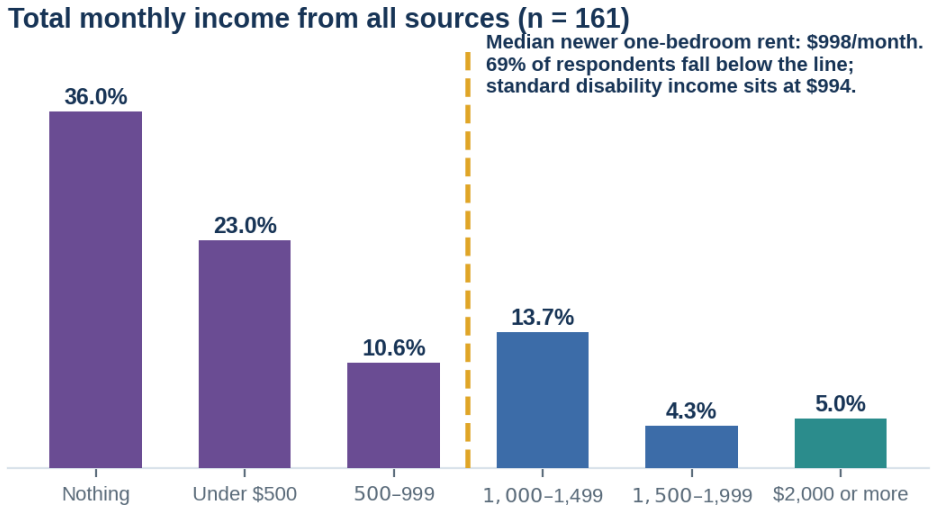


Figure 6. Monthly income among survey respondents. The gold line marks HUD's fiscal year 2025 fair market rent for a one-bedroom unit in the Salem metro area.

Source: Community member survey Q28; 8% of respondents preferred not to answer.

Table 11. Employment status and sources of income and benefits among survey respondents (N = 161)

Employment status	n	%	Sources of income and benefits (select all)	n	%
Not working, looking for work	47	29%	SNAP (food stamps benefits)	90	56%
Unable to work: disability or health	40	25%	Wages or salary from a job	38	24%
Working full-time	23	14%	No income at this time	36	22%
Working part-time	14	9%	Supplemental Security Income (SSI)	15	9%
Not working, not looking	15	9%	General Assistance or state cash	14	9%
Occasional or temporary work	8	5%	Support from family or friends	14	9%
Retired	6	4%	SSDI	12	8%
Prefer not to answer	8	5%	Informal or cash work	11	7%

This table presents respondents' employment status and income sources. The largest employment groups were respondents looking for work (29%) and respondents unable to work due to disability or health (25%), followed by those working full-time (14%). SNAP, a food benefit rather than cash income, was the most commonly reported support, at 56%. Wages were reported at 24%, while 22% reported no income at this time. Cash benefit programs each reached small shares of the sample: SSI at 9%, General Assistance at 9%, and SSDI at 8%.

4.8 Safety and Daily Conditions

Half of respondents (80 of 161) reported feeling safe where they were staying. Seventy-seven respondents reported concerns, including 20 who reported not feeling safe. Safety differed by housing situation: 76% of unsheltered respondents reported safety concerns, compared with 39% of respondents in all other situations, a statistically significant association ($p < 0.001$). Among the 78 respondents describing what made them feel unsafe, 60% cited violence, threats, or fighting around them, and 35% cited being treated unfairly or harassed because of who they are.

Table 12. Perceived safety in current living situation among survey respondents

Do you feel safe where you are currently staying?	n	%
Yes, I feel safe	80	50%
Somewhat, I have some concerns	57	35%
No, I do not feel safe	20	12%
Prefer not to answer	4	3%
Among those with concerns: what makes you feel unsafe? (select all, n = 78)	**n**	**%**

Do you feel safe where you are currently staying?	n	%
People around me: violence, threats, or fighting	47	60%
Being treated unfairly or harassed because of who I am	27	35%
My neighborhood feels unsafe	23	30%
Problems inside the home: mold, pests, or broken heat	17	22%
Something else (weather exposure, theft, and police contact in write-ins)	17	22%
Doors or windows that do not lock	12	15%
Too many people living in the home	8	10%

4.9 Connectivity

Eighteen percent of survey respondents did not have a working phone, and an additional 17% had a phone with very limited minutes or data. Ten percent had no internet access at all, and another 8% reported that access was rare and very limited. Connectivity was lower among unsheltered respondents. Forty percent reported limited or no internet access, compared to 18% of the full sample. Many of the services described in this report involve online applications, phone callbacks, or appointment confirmations. Respondents without reliable phone or internet access face additional steps to complete these processes.

Table 13. Phone and internet access among survey respondents

Working cell phone	%		Regular internet access	%
Yes, with minutes or data	65%		Yes, on my phone	66%
Yes, but minutes or data very limited	17%		Through a library, shelter, or other location	16%
No working phone	18%		Rarely, access is very limited	8%
			No access	10%

KEY TAKEAWAYS – WHO IS EXPERIENCING HOMELESSNESS

- Two-thirds of survey respondents had experienced homelessness or housing instability before the current episode, and among them, two-thirds had spent 12 or more months homeless in the past three years.
- Participant age in the listening sessions was concentrated at both ends of adulthood: roughly six in ten participants were under 25 or 55 and older. The two groups described different pathways into homelessness, family expulsion at or before eighteen for younger participants, and rent increases, job loss, divorce, or medical events for older participants.

- Three-quarters of respondents reported a long-term physical or mental health condition. 86%had health insurance, and 43% had used an emergency room in the past year because care was unavailable elsewhere.

- Among respondents reporting an income amount, 64% lived on less than $500 per month, including 36% of the sample with no income. Forty-five respondents were working while homeless or unstably housed, 23 of them full-time.

- Safety concerns differed sharply by housing situation**:** 76% of unsheltered respondents reported concerns about where they were staying, compared with 39% of respondents in all other situations. Among those describing what made them feel unsafe, violence, threats, or fighting was the most cited concern, followed by being treated unfairly or harassed because of who they are.

- Of 40 surveyed parents of minor children, 15 did not have their children with them, and 53 of 58 session participants reported no children in their household, though many identified as parents. In one documented account, a mother was separated from her son because no shelter could accommodate his disability.

- Thirty-six percent of providers reported no change in the mix of households types they serve over the past year. Among those reporting a shift, an increase in adults 65 and over was the most common response.

5. Migration, Mobility, and Community Connection

5.1 Where Participants Live and What Brought Them Here

Community member survey respondents were concentrated in Salem, which accounts for 122 of 161 respondents. The remainder were distributed across Silverton (7), Keizer (6), Stayton (6), Monmouth (5), and a dozen smaller communities including Independence, Falls City, Woodburn, and Mill City. The listening sessions drew a different geographic profile: 68% of session participants lived outside Salem, across Silverton, Monmouth, Woodburn, Stayton, Falls City, and Dallas, reflecting the placement of sessions in communities across both counties. Most participants at the Spanish-language session in Woodburn lived in Woodburn.

The survey also asked what brought respondents to the area in which they were currently residing. Among the 125 respondents who answered, the most common reason was family or loved ones, selected by 40%. Twenty percent were already living in the area when they lost their housing. Eighteen percent came fleeing an unsafe or dangerous situation, and 11% came for a relationship that has since ended. Service-related reasons were selected less often: 14% selected that sheltering and other services are located here, and 9% selected having heard there were more services or resources here. Two respondents reported being referred or transported to the area by another agency, and three reported being discharged from a hospital, jail, or facility in the area.

Table 14. Reasons community member respondents moved to the region

What brought you to this area? (select all, n = 125 answering)	n	%
Family or loved ones are here	50	40%
Already living here when I lost my housing	25	20%
Fleeing an unsafe or dangerous situation	22	18%
This is where sheltering and other services are located	18	14%
Came for work or a job opportunity	16	13%
Came for a relationship that has since ended	14	11%
Heard there were more services or resources here	11	9%
Cost of living seemed more affordable	5	4%
Discharged from a hospital, jail, or facility in this area	3	2%
Referred or transported here by another agency	2	2%

Note. Community member survey Q14 (n = 125 answering). Select all that apply; percentages sum to more than 100.

Respondents' ties to the area ran deep in most cases. Forty-two percent either grew up in the area or had lived there more than ten years; an additional 19% had been in the area four to ten years and 18% had arrived within the past six months. Among respondents who had moved to the area at some point, the most common origin was another Oregon county (36%), followed by somewhere else within Marion or Polk County (29%) and another state (25%). Write-in responses identify the specific origins. Of the 79 respondents naming a place, 44 came from elsewhere in Oregon, most commonly neighboring Linn, Lincoln, and Clackamas

Counties and the Portland and Eugene areas. Washington State accounted for 10 and California for 7.

The survey also asked whether respondents have family, close friends, or other support people in the area. Sixty-one percent reported connections of some kind: 29% described strong connections and 32% described connections that are not very close. Twenty-two percent reported no connections in the area, and 17% reported that they had connections in the area but that those connections are no longer available. Thirty percent of respondents named family breakdown as a contributing factor to their housing loss. These findings are consistent across the items in this section. Most respondents have longstanding ties to the area, arrived from elsewhere in Oregon when they did move, and came for family more often than for services.

Table 15. Origins and local support connections among survey respondents

Where people came from	%		Support people in this area	%
Another Oregon county	36%		Some connections, not very close	32%
Elsewhere in Marion or Polk County	29%		Strong connections here	29%
Another state	25%		No connections here	22%
Always lived here	6%		Had connections, no longer available	17%

When community member survey respondents were asked where they would ideally live, 52% chose Marion or Polk County, naming it as their community. Twenty-one percent chose elsewhere in Oregon, and 12% chose another state where they have connections. When asked where they feel most at home, respondents mostly commonly answered Salem (44%). **Nineteen percent answered that they do not really feel at home anywhere right now**.

> *"I am not homeless just houseless. Home is where the heart is."*
>
> Community Member survey respondent

5.2 What Providers See

The provider survey asked where the clients they serve are primarily coming from, an item designed to parallel the community member questions about origins. **Eighty-four percent of providers reported that the majority of their clients became homeless in Marion or Polk County. Nine percent identified an origin outside the two counties.**

The provider listening session added a within-region pattern to this picture. Providers described rural residents across both counties being directed to Salem, where most services are located, at volumes Salem's programs described being unable to absorb. This account is consistent with the geographic findings elsewhere in this report, in which services concentrate in Salem while need is distributed across both counties.

Providers also described individual clients arriving from outside the region. These accounts included people arriving by bus from Washington, Grants Pass, and further away, and arrivals

from Eastern Oregon and Southern Washington who, after a year without securing housing, asked for help returning home. **These individual accounts and the aggregate figures describe the same system at different scales. Providers encounter out-of-region arrivals as individual cases, while the survey data, from both providers and community members, indicate that most people experiencing homelessness in the region became homeless here.**

Forty-two percent of surveyed community members grew up here or have lived here more than a decade. Among those who moved here, family ties outrank service availability as the reason for moving by roughly three to one. Only two respondents in the entire sample were transported here by an agency. Eighty-four percent of providers say their clients became homeless locally. The dominant migration pattern the data shows is intra-regional movement toward Salem, produced substantially by the region's own referral practices, which direct people from rural communities to a city whose capacity is already exhausted.

KEY TAKEAWAYS – MIGRATION, MOBILITY, AND COMMUNITY CONNECTION

This population is largely local. Most community member survey respondents had long ties to the region. Forty-two percent grew up here or had lived here more than ten years. In the provider survey, 84% of providers said most of their clients became homeless in Marion or Polk County.

Family, not services, is why movers came. Family ties outrank service availability roughly three to one, and only two respondents reported being transported here by an agency.

The dominant flow is intra-regional, toward Salem, driven by referral practices that tell rural residents the resources are in a city that cannot absorb them.

More than half of respondents want to stay in this region, and one in five do not feel at home anywhere right now.

6. Pathways Into Homelessness

Every person experiencing homelessness in this assessment was once housed. This section examines how that changed. It draws on three sources that each capture a different part of the answer: community member survey respondents described where they were living before the loss, the first event that set it in motion, and the factors that compounded it. In addition, providers described the reasons clients share with them. The section begins with what respondents' histories show about recurrence, then turns to where people were housed before the loss, what happened first, and what else contributed.

Of the 161 community member survey respondents, 103 reported experiencing homelessness or housing instability before the current episode; 51 reported this as their first time, and 7 preferred not to answer. The 103 respondents with prior episodes were asked two follow-up questions covering the past three years. The first asked how many separate times they had experienced homelessness, and the second asked how many total months they had spent homeless.

Table 16. Recurrence and duration of homelessness among respondents with prior episodes

Among the 103 with prior episodes: separate times homeless, past 3 years	%		Total months homeless, past 3 years	%
2 times	52%		12 months or more	66%
4 or more times	32%		Less than 6 months	21 %
3 times	17%		6 to 11 months	13%

Note. Community member survey Q3a and Q3b, asked of the 103 respondents who reported prior homelessness or housing instability. Percentages are of the 103 and are rounded to whole numbers.

6.1 Housing Situation Before Loss

Respondents were also asked where they were living before losing their housing. More than a third, 34%, were renting an apartment or house on their own, and another 8% were renting with roommates. An additional 37% were living with family or a partner, a figure combining the 22% living with family and the 16% living with a partner or spouse. Six respondents had owned a home. Thirteen respondents reported having been homeless or unstably housed for most of their lives.

Table 17. Housing situation and housing assistance before losing housing

Housing situation before losing stable housing	n	%		Voucher or subsidy before housing loss	n	%
Renting on my own	55	34%		No voucher or subsidy	108	67%
Living with family	35	22%		Don't know	16	10%
Living with a partner or spouse	25	16%		On a waiting list, never received	15	9%
Homeless or unstable most of my life	13	8%		Held a Section 8 / HCV	14	9%

Housing situation before losing stable housing	n	%		Voucher or subsidy before housing loss	n	%
Renting with roommates	12	8%		Held another rental subsidy	6	4%
Owning a home	6	4%		Applied, denied or removed	2	1%
Other	15	9%				

Combining the housing categories shows where respondents stood before the loss. Fifty-seven percent of respondents were renting on their own, renting with roommates, or living with a partner or spouse before losing their housing. Most respondents were not receiving housing assistance before the loss. Sixty-seven percent held their housing without a voucher or subsidy. Twelve percent of respondents had held a Section 8 Housing Choice Voucher or another rental subsidy before losing housing. In addition, 9% were on a waiting list that had not yet reached them, and two respondents had applied and had been denied or removed.

The 20 respondents who had held a voucher and lost it were asked what happened. The most common response was a write-in, given by 8 respondents, with one describing a landlord ending a voucher without the tenant knowing. Four had their subsidy terminated by the housing authority, and four left voluntarily. Three were evicted, and three had their voucher expire before finding housing.

When asked about the first thing that started their path to losing housing, respondents most commonly described a relationship ending at 16%, followed by no longer being able to afford rent at 13% and having to leave because of domestic violence or an unsafe situation at 12%. Job loss followed at 11%, eviction at 7%, and a mental health crisis at 6%. The largest single response was a write-in, at 20%, with entries frequently describing a property being sold, a landlord decision, or a compound event that did not fit the offered categories, and ten respondents said it happened gradually with no single event.

Table 18. The first event that started the path to losing housing

The first event that started the path to losing housing (select one)	n	%
Other (write-in, largely coded to employment, family, and health)	32	20%
A relationship ended (divorce, breakup, death of a partner)	25	16%
Could no longer afford rent	21	13%
Had to leave because of domestic violence or an unsafe situation	20	12%
Lost a job or income dropped significantly	17	11%
Evicted	11	7%
A mental health crisis	10	6%
It happened gradually, no single event	10	6%
Substance use	8	5%
A serious physical health problem	4	3%

The first event that started the path to losing housing (select one)	n	%
Fire or disaster, aging out of foster care, or release from custody	3	2%

Note. Community member survey (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100. Write-in responses coded as Other most often described employment, family, and health circumstances; the full coding crosswalk appears in the component report appendices.

> *"I was doing fine, and suddenly I was left with nothing. I had saved up."*
>
> Community Member Listening Session, Woodburn
>
> *"I have been homeless since 1984. I've gotten on my feet several times, but something would change and I would be homeless again."*
>
> Community Member Listening Session, Stayton

6.2 Contributing Factors

Few respondents described their housing loss as having a single cause. Alongside the first-event item, the survey asked what other factors contributed, and respondents selected an average of between two and three contributing factors. **The responses show housing loss arriving through several circumstances at once, with economic, health, and relationship factors each appearing in a substantial share of accounts.**

The multi-select contributing factors question gives the fuller picture. **Could not afford rent or was priced out was the most selected factor, at 38%.** Mental health challenges followed at 33%. Family breakdown or conflict and job loss were each selected at 30% each. The lack of affordable housing in the area followed at 20%, physical health challenges at 19%, substance use at 18%, domestic violence at 17% , and eviction at 15%. Housing loss in this sample is typically described as several things happening at once.

Domestic violence as a contributing factor differed by gender identity. It was cited by 23% of women and 36% of gender non-binary respondents (e.g., trans, and gender non-confirming respondents) compared with 7% of men.

Table 19. Factors contributing to housing loss among survey respondents

Contributing factors (select all that apply)	n	%
Could not afford rent or was priced out	**61**	**38%**
Mental health challenges	**52**	**33%**
Family breakdown or conflict	**48**	**30%**
Job loss or reduced income	**48**	**30%**
Lack of affordable housing in the area	32	20%
Physical health challenges	30	19%
Substance use	29	18%

Contributing factors (select all that apply)	n	%
Domestic violence or an unsafe situation	27	17%
Eviction	24	15%
Discrimination (race, gender, identity, or background)	11	7%
Release from jail, prison, or detention	9	6%
Disaster or fire, foster care aging-out, or institutional discharge	9	6%

Note. Community member survey Q21, select all that apply (n = 160 answering). Percentages sum to more than 100. Respondents selected an average of 2.5 factors. The disaster, foster care, and institutional discharge row combines three options selected 5, 2, and 2 times respectively.

Taken together, these findings describe housing loss as a compound event. **A first event set the path in motion, most often a relationship ending, unaffordable rent, or an unsafe situation, and additional factors accumulated around it, with respondents selecting between two and three contributing factors on average.** Economic pressure, health challenges, and relationship breakdown each appeared in roughly a third of accounts, and no single factor was selected by more than 38% of respondents. The pattern varied by who was describing it, with domestic violence appearing far more often in the accounts of women and gender non-binary respondents than of men.

6.3 Institutional Pathways

In the community member survey, release from jail, prison, or detention was a contributing factor for 6% of the respondents, and discharge from a hospital or treatment program without housing for 1%. Providers reported encountering these circumstances far more often. **Forty-nine percent of providers cited release from jail or prison without stable housing and 40%cite discharge from a hospital or treatment program among the reasons clients most commonly share as contributing factors to becoming homeless**

Formal data sharing agreements with these institutions were uncommon among provider respondents. Four percent of provider respondents reported an agreement with criminal legal partners, and 9% with hospitals. Providers thus reported institutional discharge among the most common circumstances they see, and reported few formal connections (e.g., data sharing agreement, MOU, or formal agreement) to these discharging institutions. It is unclear why so few formal connections exist.

The provider listening session added foster care and behavioral health facilities to that list. Providers also described a circumstance affecting people under criminal justice supervision. For this group, remaining homeless can violate the terms of their supervision, while their criminal record disqualifies them from many of the housing options that would resolve it. Providers described people held between these two requirements, unable to satisfy one without the other.

> *"The catch-22 with crime, and especially with sexual crime, is that they can break their probation or parole if they are homeless, but nobody's going to rent to them. So, they get*

> *shipped back to jail for a probation violation that they had no control over, and then it just repeats the cycle once they get released."*
>
> Service Provider, Listening session
>
> *"It's not just housing that they'll get denied for. It's also shelter. We have policies at our shelter that certain crimes will disqualify you from entering shelter."*
>
> Service Provider, Listening session
>
> *"I was actually denied one of the housing vouchers that the shelter I was staying at helped signed me up for. I was denied because of me having a felony on my record. I got that felony back in 2016. Ten years ago!"*
>
> Community Member Listening Session, Salem

6.4 What the Journey Mapping Showed

The journey mapping activity during the community member listening sessions showed the structure of these pathways. Across the maps, **housing loss appeared as a cascade rather than a single event.** Almost no participant described a single cause. Instead, the maps showed sequences. A layoff met a rent increase. A car breakdown was followed by a hospitalization. A lost phone was coupled with a missed callback for a job or an important appointment. Participants who could name a first event, such as a mother's death, an eviction, a divorce, being told at fifteen to leave, described everything after it as consequences compounding on one another.

The journey maps also surfaced two distinct pathway archetypes that match the bimodal age profile mentioned earlier in the report. The first pathway belongs to youth. The youth pathway runs through family rupture, expulsion or flight from home at or before eighteen, including at ages as young as 13, 15, and 17 among participants, sometimes tied to identity or safety at home. One participant described it plainly during the session, *“My journey started in the summer of 2022, when I turned 18. My mother decided that I wasn’t her problem anymore, and so I got kicked out.”*

The second pathway belongs to older adults. This pathway runs through economic and medical shock late in a working life, a layoff, a divorce, a stroke, a rent increase against a fixed income. A Salem participant with a forty-two-year career in cabinetry connected his loss in housing to a single termination. *"I used to be the boss. I was the head of 25 people at the shop. Then I got fired four years ago."*

Health, injury, and disability appeared as both trigger and consequence, most often in older participants’ accounts. In some accounts it was the starting point, and in others it arrived mid-sequence, as a coping mechanism for the other traumatic events they were experiencing. Substance use appears in participants' accounts as frequently entangled with grief and loss.

> *"You can't look for work in dirty clothes and no real place to get cleaned up."*
>
> Community Member Listening Session, Monmouth
>
> *“At the age of 13, I ran away from home because I got tired of being a punching bag.”*
>
> Community Member Listening Session, Salem

6.5 Structural Drivers

Providers were asked about the reasons clients most commonly share as the cause of their housing situations. **Inability to afford rent leads decisively at 87%.** Substance use followed at 72% and chronic long-term homelessness at 68%. In the provider listening session, providers described the structural conditions behind these reasons. Service providers described rents set above fixed incomes, income requirements set at multiples no benefit recipient can meet, and funding for services shrinking while demand grows.

The provider data also contain a difference between what providers cited as causes and what they cited as needs. Seventy-two percent of providers included substance use among the reasons clients commonly give for becoming homeless, and 64% cited a mental health crisis as a common cause. These two conditions each run through most providers’ caseloads, and they frequently occur together in the same person. When both conditions occur together, treatment calls for dual diagnosis support. These are services that treat both conditions at once, instead of separate systems that can each turn the same person away. Yet when providers named needed services, substance use treatment was selected by 60% of providers and dual diagnosis support selected by 46%.

6.6 What Has Changed

Providers were also asked how the factors driving homelessness have shifted. The change providers most often described was the aging of the population entering homelessness, with first-time homelessness among older adults on fixed incomes appearing in both the survey write-ins and the provider session. Older adults ranked second among population providers identified as falling through the cracks. Providers and participants also described newly homeless older adults fitting poorly into existing program criteria, which are often built around families with children or around chronic homelessness.

Providers also described funding reductions changing what the system itself can do. One peer-run recovery center lost 78% of its funding. A behavioral health grant was cut by 12%, and the organization removed coordination meetings first, these were meetings the organization established to have consistent touch points with other agencies in the region to stay informed of the various services offered to current and potential clients. Providers connected that loss to less accurate referrals, which participants experience as being sent from agency to agency, a pattern described later in this report.

The accounts from service providers and those experiencing homeless agree on several points. Both groups name affordability as the leading driver of homelessness. Both name release from

jail, prison, hospital, or treatment as a pathway into homelessness. Both describe several causes compounding rather than single causes acting alone. The two accounts differ most in how often they name substance use. Seventy-two percent of providers included substance use among the reasons clients most commonly share, compared with 18% of community members who cited it as a contributing factor. Five percent of community members described substance use as the first event. Release from jail or prison showed a similar gap, named by 49% of providers and 6% of community members. Two circumstances help explain these differences. The first is disclosure. Substance use carries stigma, which can make people less likely to report it. The second is vantage point. Each provider reported on patterns across an entire caseload, while each community member reported on one life, their own. A circumstance can appear often across a caseload and still show up in one person's account as a later consequence, not a starting cause. Participants described substance use following grief, injury, and the conditions of living outside as often as preceding them.

KEY TAKEAWAYS – PATHWAYS INTO HOMELESSNESS

Most respondents had lost housing before. Of the 103 respondents with prior episodes, 66% had spent a year or more of the past three years homeless. Thirty-two percent had experienced four or more separate episodes in that window.

Before the loss, most respondents held conventional housing without assistance. Fifty-seven percent were renting on their own, with roommates, or living with a partner, and 67% had no voucher or subsidy. Fifteen respondents were on a waiting list for assistance when their housing was lost.

No single cause dominated the accounts. Respondents selected an average of between two and three contributing factors, the most selected factor reached only 38%, and the journey maps showed the same structure, with first events followed by compounding consequences.

Affordability appeared at the top of both community member and provider accounts. **Could not afford rent was the most selected contributing factor among community members at 38%**, and 87% of service providers included inability to afford rent among the reasons clients commonly reported.

Two pathways ran through the journey maps, matching the ages of session participants. Younger participants described family rupture at or before eighteen. Older participants described economic and medical shocks late in a working life, arriving against fixed incomes.

Providers reported institutional release as a common circumstance and have few formal connections to the releasing institutions. Forty-nine percent cited release from jail or prison without stable housing, while 4% of providers reported a formal data sharing agreement with criminal legal partners, and 9% with hospitals.

The provider and community accounts differed most on substance use, reported by 72% of providers and cited by 18% of community members. Participants' accounts described substance use following grief, injury, and life outside as often as preceding them.

7. Prevention and Diversion

7.1 What Support Existed Before Housing Loss

Most community member survey respondents entered homelessness without prevention assistance. Sixty-one percent received no support or services at all before losing their housing. Another 8% did not know support was available. Together, 69% of the sample lost housing without any prevention support reaching them.

Fifty respondents (31%) did receive support of some kind. Among this group, food assistance was the most common form, received by 64%. Help from a friend or family member followed at 38%. Rental assistance or help paying rent reached 40% of the group, which is 20 respondents out of the full sample of 161. Case management or a housing advocate, the intervention most closely associated with housing retention, reached three respondents (2%). **The support that reached people most often addressed immediate needs, while the forms of support most directly tied to keeping housing reached far fewer.**

Support that did arrive did not always prevent the loss. **Of the 50 respondents who received support, 40% reported that it was not enough to prevent homelessness.** The remaining 60% reported that it helped for a while. Before the loss, 20 respondents held a voucher or subsidy, and 15 more were on waiting lists that had not yet reached them.

Table 20. Prevention support received before losing housing among survey respondents

Support received before losing housing	n	%
No support at all	98	61%
Had support, and it helped for a while	30	19%
Had support, but it was not enough to prevent homelessness	20	12%
Did not know support was available	13	8%

Note. Community member survey (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100.

> *"Sometimes the rent is too much, and we have a thousand other utilities to pay. With gas prices going up, we barely get by, living paycheck to paycheck, and sometimes we do not have money to do laundry."*
>
> Community Member Listening Session, Woodburn

7.2 What People Say Would Have Prevented It

One hundred fifty-seven respondents answered an open-ended question about what could have prevented their housing loss. The most common theme was employment, income, or wages, appearing in 23% of responses. Family, relationship, and domestic violence circumstances followed at 20%, and substance use and recovery at 15%. Case

management, navigation, or peer support appeared in 9% of responses. Housing affordability appeared in 8%, and rent or financial assistance in 5%.

Two groups of responses stood apart from the themes above. Fifteen percent of respondents wrote that nothing could have prevented the loss. These answers most often followed a death, a fire, or an exit from violence. One respondent wrote, "There's nothing I could have done. My roommate was arrested for threatening to shoot my son in the face. That led to the eviction and I couldn't afford a place."

Another 7% described the cause in terms of their own choices, using language of self-blame. One person wrote, *"I should have not used any drugs in the first place, kept my job so I could pay rent. There's a long list of wrong turns I took instead of the right ones."* The remaining responses, more than three in four, described circumstances that respondents believed could have been different.

The responses describe prevention in different terms. Some respondents named specific circumstances a program could address, such as waitlist length, income requirements, deposit structures, and document requirements. Others described the loss as unpreventable or as their own doing. Both kinds of account came from people who had lost their housing. Some located the cause in circumstances outside themselves, and others located it in their own choices.

The contrast between response types is important. A substantial group described concrete, addressable system failures, naming waitlist length, income multiples, deposit structures, and document requirements. A separate group described the loss as unpreventable or as their own fault.

> *"Affordable housing options that do not require income equal to 2-3x amount of monthly rent, deposit flexibility to allow it to be divided and paid over time instead of all at once upon moving in."*
>
> Community Member, Survey respondent

7.3 The Provider Perspective of the Prevention Landscape

The service provider survey also asked providers about their prevention and diversion practices. Prevention refers to support that helps households keep housing they are about to lose. Diversion refers to resolving a housing crisis at the point of shelter entry, without the person entering the shelter system. Both practices exist in the region, and the survey asked each provider to characterize where their organization stands.

Among providers, 34% describe housing prevention as a formal or core practice and 33% as informal or limited. **For diversion, 24% described a formal practice, and 36% described an informal or limited one.** The responses show roughly a third of providers practicing prevention and diversion without a formal program behind the work.

Providers described diverting people from shelter entry when they can. This work happens without a formal program or dedicated funding, and program measures do not capture it. An additional 11% of providers reported that they would like to expand diversion.

Table 21. Provider practice of housing prevention and diversion

Practice	Formal or core practice	Informal or limited	Not our focus	Would like to expand
Housing prevention	34%	33%	23%	9%
Housing diversion	24%	36%	29%	11%

Note. Service provider survey (n = 90). Each practice was rated on one scale; percentages are of respondents answering and are rounded, so rows may not sum to 100.

7.4 What Providers Say Would Help Them Expand

Providers were then asked what would most help them expand low-barrier, diversion, and prevention work. Flexible funding not tied to restrictive program requirements was the most selected option at 57%. Additional or specialized staffing followed at 44%, and funder policy changes that allow more flexibility at 34%. Community education to reduce opposition was selected by 30%, and a shared regional diversion fund accessible to multiple providers by 20%. Technical assistance or training on low-barrier models was selected by 17%, and 12% reported that they are already where they need to be.

The pattern across the options is descriptive of what providers identified. The three most selected options concern funding and the conditions attached to it. The least selected option concerns training. Providers most often identified the structure of funding, rather than knowledge of the models, as what stands between their current practice and expanded practice.

Table 22. What providers report would most help expand low-barrier, diversion, and prevention work

What would most help expand low-barrier, diversion, and prevention work	%
Flexible funding not tied to restrictive program requirements	57%
Additional staffing or specialized staff	44%
Funder policy changes that allow more flexibility	34%
Community education to reduce opposition	30%
I don't know	21%
Shared regional diversion fund accessible to multiple providers	20%
Technical assistance or training on low-barrier models	17%
We are already where we need to be	12%

Note. Service provider survey (n = 90 answering). Select all that apply; percentages sum to more than 100.

7.5 The Prevention Gap

The community and provider accounts describe the same circumstance from two sides. Community members described a prevention system that reached few people before their housing loss. Providers described prevention and diversion practiced informally, without dedicated funding or metrics to capture their work in this area. Most providers named flexible funding as what would help them expand it.

The community member survey also identifies the group for whom prevention remains most crucial. Twenty-nine community member survey respondents were housed but at risk or doubled up at the time of the survey. Among this group, rent and deposit assistance was the most named need, selected by 52% of respondents, ahead of permanent housing.

The open-ended responses offer one additional consideration. Roughly one in five respondents named rent, deposit, or income assistance as something that could have prevented their loss, and another one in ten named navigation or case management. Fifteen percent wrote that nothing could have prevented it.

KEY TAKEAWAYS – PREVENTION AND DIVERSION

Most respondents lost housing without prevention support reaching them. Sixty-nine percent received no support or did not know it was available. Rental assistance reached 20 respondents of 161, and case management reached three respondents.

Support that did arrive did not always prevent the loss. Of the 50 respondents who received support, 40% reported it was not enough to keep their housing.

Asked what could have prevented their loss, respondents most often named income, family circumstances, and recovery. Fifteen percent wrote that nothing could have prevented it, and 7% described the loss in terms of their own choices.

Roughly a third of providers practice prevention and diversion informally, without a formal program, dedicated funding, or measurement behind the work.

Asked what would most help them expand this work, providers most often selected flexible funding not tied to restrictive requirements, at 57%. Training ranked near the bottom at 17%.

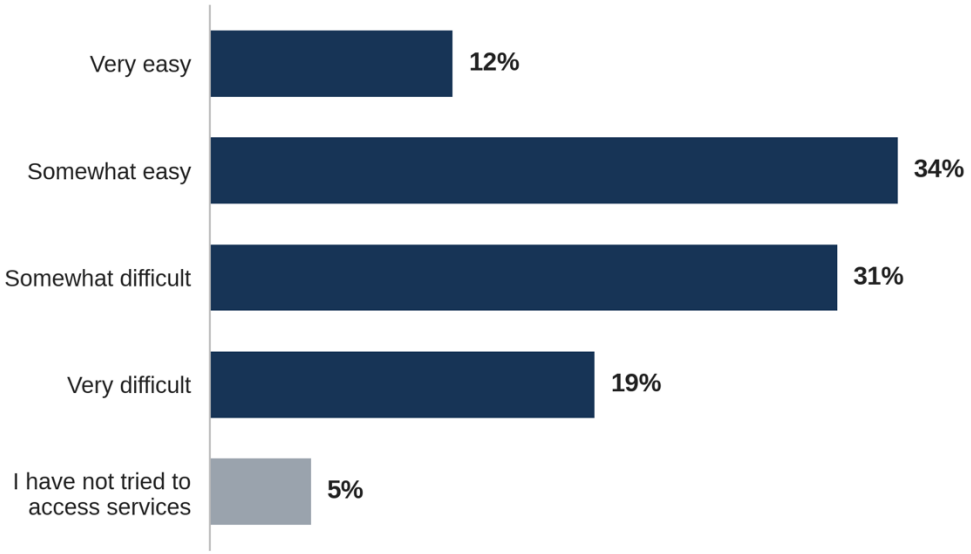
Among the 29 respondents who were housed but at risk or doubled up, rent and deposit assistance was the most named need, at 52%, ahead of permanent housing.

8. Barriers to Services and Housing

This section examines what stands between people and the services or housing they seek. It draws on the community member survey items about barriers, being turned away, and employment. This section also highlights the provider survey items about barriers and program requirements and findings from the listening session that captures participants perspectives on the rules and requirements that blocked them from accessing those services.

8.1 Ease of Access Overall

The community member survey asked respondents how easy or difficult it is to access services when they need them. Responses divided almost evenly. Forty-six percent found services somewhat or very easy to access. Fifty percent found them somewhat or very difficult, including 30 respondents, or 19%, who described access as very difficult. Eight respondents (5%) had not tried to access services. Unsheltered respondents, parents, and people who have been homeless longest reported more difficulty accessing services.



Source. Community member survey (n = 161), single-response item. Percentages sum to more than 100 due to rounding.

Figure 7. Ease of accessing services among survey respondents (N = 161)

8.2 Barriers Reported by Community Members

The survey asked respondents to select the biggest barriers they face in accessing housing and shelter services. Their answers describe several kinds of barriers. Some barriers reflect the supply of services, such as waitlists that form when more people seek a service than it can serve. Some reflect the practical work of reaching services, such as the transportation to get there and the distance to travel, which matter most for people without a vehicle or living outside Salem. Others reflect the rules attached to services, such as pet policies, requirements that separate family members or partners at entry, and sobriety conditions that a person must meet

before being admitted. The most selected barrier falls outside all three groups. It concerns information, meaning respondents did not know what services existed or how to find them.

Not knowing what services are available or how to find them was selected by 48% of respondents. Long waitlists followed at 42% , and lack of transportation at 30%. A second group of barriers was selected by roughly one in five respondents. Being told they do not qualify was selected by 22%. Distance was selected by 18%. Not feeling safe at shelters and being unable to bring a pet were each selected by 17%. Being separated from a family member or partner and having a disability that makes access difficult were each selected by 11%.

The remaining barriers were each selected by fewer than one in ten respondents, among them documentation, a bad past experience with a provider, sobriety requirements, and a criminal history. Ten respondents, 6%, reported facing no barrier. No respondent selected services not available in their language, a result that reflects the survey's largely English-preferring sample rather than the absence of language need in the region.

Table 23. Biggest barriers to accessing housing and shelter services among survey respondents (N = 161)

Biggest barriers to accessing housing and shelter services (select all)	n	%
I don't know what services are available or how to find them	**77**	**48%**
Waitlists are too long	**68**	**42%**
I don't have transportation	49	30%
I was told I don't qualify	36	22%
Services are too far away or hard to get to	29	18%
I don't feel safe at shelters	27	17%
I cannot bring my pet	27	17%
Not allowed to bring a family member or partner	17	11%
A disability makes access difficult	17	11%
I prefer to manage on my own	11	7%
No required ID or documents	11	7%
A bad past experience with a provider	11	7%
No barrier: I can access services when I need them	10	6%
Sobriety requirements I could not meet	9	6%
Outstanding warrant or criminal history	9	6%
Services do not feel culturally welcoming	5	3%
Services not available in my language	0	---

The barriers people face differ with where they are living. The table below shows the ten most selected barriers within each of four housing situations.

The information barrier was the most selected barrier in every group except the unsheltered group, and it was highest among respondents housed but at risk or doubled up, at 62%, and among those currently housed, at 56%. A**mong unsheltered respondents, long waitlists ranked first** at 44%, with the information barrier close behind at 40%. Transportation was selected by about a third of unsheltered and sheltered respondents and by fewer of those housed.

Two barriers separated the unsheltered group from the others. Being unable to bring a pet was selected by 31% of unsheltered respondents, compared with 3% of sheltered respondents. Not being allowed to bring a family member or partner was selected by 15% of unsheltered respondents, compared with 5% of sheltered respondents. These two barriers describe conditions of shelter entry, and they appear most often among the people who have not entered.

Being told they do not qualify was selected at similar rates across all four groups, between 19% and 28% . Distance was selected most often by respondents at risk or doubled up, at 28%. Preferring to manage on their own was selected by 14% of respondents at risk or doubled up, higher than in any other group.

Table 24. Barriers to accessing services by housing situation

Item	Unsheltered (n=48)	Sheltered (n=64)	At risk or doubled up (n=29)	Currently housed (n=18)
I don't know what services are available or how to find them	**40%**	**47%**	**62%**	**56%**
Waitlists are too long	**44%**	**48%**	**38%**	**28%**
I don't have transportation	35%	34%	24%	17%
I was told I don't qualify	25%	19%	24%	28%
Services are too far away or hard to get to	15%	14%	28%	22%
I don't feel safe at shelters	21%	17%	14%	11%
I cannot bring my pet	31%	3%	21%	22%
I was not allowed to bring a family member or partner	15%	5%	7%	17%
I have a disability that makes access difficult	15%	9%	14%	--
I prefer to manage on my own	6%	5%	14%	6%

Note. Community member survey Q34 by recoded housing situation (n = 159; two respondents could not be classified). Percentages are within each group. Select all that apply, so columns sum to more than 100. Sheltered combines emergency and transitional shelter. At risk or doubled up combines respondents housed but at risk of losing it and those staying temporarily with others. Currently housed refers to respondents recently housed after a period of homelessness. Rows shown are the ten most selected barriers overall.

8.3 Being Turned Away

Forty-five percent of respondents had been turned away from a shelter or housing program, and an additional 24% of respondents did not know whether they had been. Among the 73 respondents who had been turned away, a full shelter was the most common reason, reported by 36%. The next two reasons described something other than capacity. **Seventeen respondents (23%) were told they did not qualify without being given a reason. Sixteen respondents (22%) were turned away because of a pet.**

Criminal history followed at 12%. Being unable to bring a partner or family member was reported by 11%, sobriety requirements by 10%, and missing identification by 8%. A refusal without an explanation differs from a refusal because the shelter is full. **When a shelter is full, the person knows the reason and can return or try elsewhere. When no reason is given, the person has no stated condition to meet and no clear next step. This finding pairs with the 48%of respondents who did not know what services were available. Together, the two describe difficulty at both ends of the process, in learning what exists and in understanding why access was denied.**

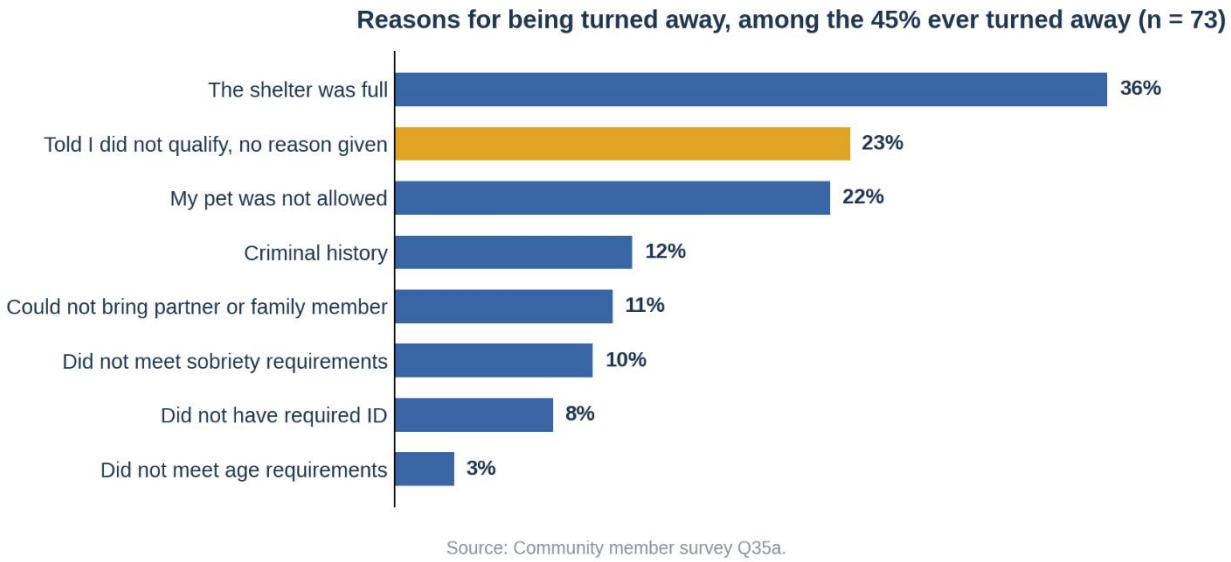


Figure 8. Reasons respondents were turned away from shelter or services. The gold bar marks respondents who were told they did not qualify without being given a reason, the second most common response.

8.4 Barriers to Employment

The survey also asked respondents what barriers stood between them and employment. Disability or a health condition was the most selected barrier, at 35%. The next two barriers describe circumstances that follow from homelessness rather than lead to it. Lack of transportation to get to work was selected by 27%. Lack of stable housing or a safe place to get ready for work was selected by 23%. Applying for jobs without being hired followed at 22%, and a criminal record that limits options at 21%. Needing more training, education, or skills was

selected by 16%. A smaller number of community members cited lacking required identification, at 8%, not finding a job that pays enough, at 6%, and lacking childcare, at 5%. Seventeen percent of respondents reported that employment is not a barrier for them right now.

Two of the most selected barriers, transportation and a place to get ready for work, are conditions that stable housing would resolve. In these responses, the absence of housing appears as an obstacle to the employment that could help secure housing. The same relationship appears in the economic findings earlier in this report, where job loss preceded housing loss for some respondents and housing loss now blocks employment for others. Income or employment support was named among the top three unmet needs by 27% of respondents.

Table 25. Barriers to employment among survey respondents (N = 161)

Employment barrier	n	%
I cannot work due to a disability or health condition	57	35%
I do not have transportation to get to work	43	27%
I do not have stable housing or a safe place to get ready for work	37	23%
I have been applying for jobs but have not been hired	35	22%
I have a criminal record that limits my options	34	21%
Employment is not a barrier for me right now	28	17%
I need more training, education, or skills	26	16%
I do not have the required ID or documents	13	8%
I have not been able to find a job that pays enough	10	6%
I do not have childcare	8	5%

Note. Community member survey, select all that apply (n = 161). Percentages sum to more than 100. The item was introduced as applying to respondents not currently working, but responses were recorded across the full sample, including the 28 respondents who selected that employment is not a barrier; percentages are therefore reported against all 161 respondents. Rows shown are the ten most selected; a further 12 respondents selected Other.

Listening session participants described the daily task of managing their belongings as its own obstacle to appearing anywhere that requires appearing well. Without a secure place to leave possessions, a person carries them, and arriving at an interview with everything they own marks them before a word is spoken. Leaving possessions behind risks losing them. A Salem participant described the situation during the session. *"The reason I mentioned the safe place to keep your stuff is because you can't go to court hauling all these bags, but you can't leave them anywhere either, because people will steal them, and you can't go to a doctor's appointment or a job interview like that."* Having housing or a secure place to place their belongings would help over a common barrier they experience with trying to access employment.

8.5 Structural Access Barriers

Reaching services and work depends on a set of practical conditions. A person needs a way to get there, identification to enroll, and a phone or internet connection to apply, confirm, and follow up. The survey measured each of these, and each was missing for a substantial share of respondents. Thirty percent lacked transportation to services, and 27% lacked transportation to work. Eighteen percent had no working phone, and among unsheltered respondents, 40% had limited or no internet access. Seven percent of respondents lacked the identification or documents required for services, and 8% lacked them for employment.

The listening sessions described how the identification barrier works in practice. A replacement Oregon identification card costs roughly $44. Homelessness declaration vouchers waive the fee, but a person may use only a limited number within a set period. **Participants described identification being stolen, lost during encampment sweeps, and destroyed in flooding, sometimes more than once in a year, so the replacement limit could be reached before the year was out. Participants also described the sequence that follows. Without identification, a person cannot be hired. Without work, there is no money for the replacement fee. Several young adults described this sequence as the barrier standing between them and employment.**

> *"You need your ID to make money, and you need money to get your ID."*
>
> Community Member Listening Session, Salem

8.6 What Providers Identify as Client Barriers

The provider survey asked the parallel question, and the barriers providers identified overlap with the barriers community members identified. **Long waitlists were selected by 81% of providers, transportation by 80%, and clients' lack of awareness about available services by 78%.** No phone or internet access followed at 64%, and inability to bring pets or partners at 59%. **The two sources rank these barriers differently, with community members placing information first and providers placing waitlists first, but the same five barriers appear near the top of both lists**.

The awareness and connectivity findings describe a related circumstance. More than three-quarters of providers reported that clients do not know what services exist. On the community side, 18% of respondents had no working phone, 18% had limited or no internet access, and among unsheltered respondents the internet figure rose to 40%. **Learning what services exist depends in part on the means to search, call, and follow up, and a share of the people the information barrier affects most are also the people with the least connectivity to overcome it.**

In an open-ended response, one provider described a barrier that neither survey had listed among its options. The provider explained that completing an application or intake requires sustained attention, organization, and follow-through, capacities that a person in crisis, without sleep, or managing a health condition may not have available in the moment. The provider also described a second circumstance. The staff who are physically present with clients at high-

traffic sites, such as day centers and meal programs, are often not authorized to complete or submit applications on their behalf, so the person who could help is not the person permitted to. The write-in closed with a proposal. Additional peer and community health worker capacity at those sites, with authorization to assist directly, would let people complete processes where they already are.

> *"Mental capacity, unable to follow directions or follow through, need someone like a peer support specialist or community health worker to lead them through the process. As site assistants, we are unable to help them with paperwork or any other needs they have to find housing."*
>
> Provider Survey Write-in

8.7 Program Requirements and How Participants Experienced Them

Sixty-three percent of shelter and housing programs described themselves as having very few or no restrictive requirements. Among those programs, 52% also reported at least one active requirement. The most common was a curfew (43%), followed by required participation in activities or chose (36%), sobriety (19%), and no pets (15%). Some of these requirements come from funders, licensing, or safety needs. When asked what prevents them from lowering barriers, providers named funder requirements, safety or liability concerns, and staff capacity. A curfew can operate within a low-barrier model when it allows exceptions for work, medical needs, and late arrivals, so that a person does not lose a bed for arriving late. The provider survey did not ask how requirements are enforced. Community members' accounts, described earlier in this section, include some of these same conditions among the barriers they faced.

The landscape scan adds the system-level view of how people enter services. **Of 44 programs, 15, or 34%, accept walk-ins, meaning a person can reach them without a phone, internet access, or a prior relationship with an agency**. Seven programs require an online application. Thirteen require a referral or engagement through Coordinated Entry. Five did not report how people access their services. Referral is the most common access method across the inventory. Most programs are entered by referral, so entry depends on a prior connection to another agency.

8.8 How Access Works Outside Salem

Outside of Salem, access to help works differently. Organizations in rural communities serve people through means other than shelter beds, including hotel and motel vouchers, short-term rental assistance, and other temporary help. This assistance does not appear in a bed inventory, and it depends on the funds and rooms available at a given time. Participants in the four small-town listening sessions also describes services and local infrastructure that did not exist in their communities. Participants in Stayton described no shelter or day space. Participants in Falls City described no laundromat, no grocery store, and no public transit. Showers were improvised through friends or in the river and one resource center recently closed.

Where services did exist, participants described the terms on which they could be used. The Stayton warming center opens only when the temperature holds at or below roughly 34 degrees for three consecutive days. It operates from 6 p.m. to 8 a.m. and is staffed by two volunteers per shift. When volunteers were short, participants described signing up to staff the shelter they needed to sleep in. Food assistance in Stayton reached participants but often could not be used. Participants described four separate obstacles. The volume was insufficient. A 15-pound box had to be carried on foot, with no transportation available. Perishable contents could not be refrigerated. There was no facility for cooking. Together, they meant a person could receive food and still not be able to eat it.

The landscape scan measured the gap these accounts describe. As documented earlier in this report, Polk County holds eight programs with 84 individual beds, about 4% of regional capacity. Its shelter beds equaled 22% of the people counted as experiencing homeless in 2025. Independence, Falls City, and rural western Polk have no dedicated program. There is not any sheltered-affiliated day or resource center anywhere in Polk County, and every Polk sheltering program open to the general population reports a waitlist. Outside the Salem-Keizer area in Marion County, capacity consists of a small number of programs in Mount Angel, Silverton, Woodburn, and Mill City.

Where facilities do not exist, rural communities are not without response. Organizations in these areas serve people through means other than shelter beds, including hotel and motel vouchers, short-term rental assistance, and other forms of temporary help. This assistance does not appear in a bed inventory, and it depends on the funds and the motel rooms available at any given time, but it is the form that sheltering most often takes in communities without a facility.

For rural residents, reaching the system's core capacity generally means traveling to Salem. Providers in the listening session described rural residents across both counties being directed there. The survey shows the same circumstance from the community side. Distance was a barrier for 18%of respondents overall.

8.9 Barriers Named in Listening Sessions

The journey mapping activity asked listening session participants to name the rules that did not work for them, and the discussion that followed asked what seeking help is like. Beyond the identification sequence and the rural absences described above, three barriers appeared in every session.

The first was being sent from one agency to another. The most common phrase across sessions, worded differently in each group, was some version of "they send you somewhere else." Participants described being routed between agencies for weeks, arriving at appointments that had been cancelled without any notice reaching them, and reaching the end of a referral chain with no solution to their problem.

The second was the problem of being contacted. Participants described waitlist notifications sent by postal mail to people with no mailing address. The response

window was 30 days, and it began on the postmark date. Participants described losing waitlist positions built up over several years when a notice never reached them in time.

The third was a record that follows a person. Participants described criminal, credit, and eviction histories closing doors long after the incident, including housing denials tied to convictions more than a decade old. For people under criminal justice supervision, the record produced a bind described earlier in this report. Remaining homeless can violate the terms of supervision, while the record disqualifies the person from many of the housing options that would resolve it. Across sessions, participants asked for ban-the-box protections, which limit when an employer can ask about criminal history, to be extended to rental applications. They described the request as a chance to explain a record to a person rather than be screened out by a form.

KEY TAKEAWAYS – BARRIERS TO SERVICES AND HOUSING

Responses on ease of access divided almost evenly. Fifty percent of respondents found services somewhat or very difficult to access, and 19%described access as very difficult, with more difficulty reported by unsheltered respondents, parents, and people homeless the longest.

Not knowing what services exist was the most selected barrier among community members at 48% and 78% of providers identified the same barrier among their clients. Eighteen percent of respondents had no working phone, and 40% of unsheltered respondents had limited or no internet access.

Forty-five percent of respondents had been turned away from a shelter or housing program. A full shelter was the most common reason. The second most common was being told they did not qualify without a reason given, reported by 23% of those turned away.

Program conditions accounted for a substantial share of barriers and turn-aways. Pet restrictions were a barrier for 31% of unsheltered respondents, compared with 3% of sheltered respondents, and pets were the reason for 22% of turn-aways. Sixty-three percent of programs described themselves as having few or no restrictive requirements, while 52% of the same programs reported at least one active requirement.

Of 44 programs in the landscape scan, 15 accept walk-ins. Most programs are entered by referral, so entry depends on a prior connection to another agency.

Employment barriers and housing barriers overlapped. Lack of transportation and lack of a stable place to get ready for work were the second and third most selected employment barriers, at 27% and 23%.

Listening session participants described three barriers in every session: being sent from one agency to another, waitlist notices sent by postal mail to people without an address, and criminal, credit, and eviction records closing doors years after the underlying event.

Outside Salem, the most common barriers were absences, such as no shelter, day space, laundromat, or transit, with rural communities relying on motel vouchers and other temporary assistance where no facility exists.

In communities without a shelter facility, sheltering most often takes the form of hotel and motel vouchers and short-term rental assistance. This help does not appear in bed inventories, and it depends on the funds and rooms available at any given time.

9. Service Utilization and What Is Working

This section examines how well current services are meeting the needs of people experiencing homelessness. It draws on the community member survey items about which services respondents used, how they experienced them, and what made a positive difference. The provider survey items about exits and program strengths and the listening session material on daily navigation and community assets are also highlighted in this section.. The section begins with what services respondents used in the past year, then turns to how they found them, how they rated them, and what they said helped most.

9.1 Services Used in the Past Twelve Months

The community member survey asked respondents which services they had used in the past 12 months. Their answers describe a pattern of use shaped by immediate need. **The services most respondents had reached were the ones that address the day at hand such as food, benefits, and medical care.** Benefits assistance, covering SNAP, Medicaid, and Social Security, reached 60% of respondents. Food pantries and meal programs reached 55%, and health or medical care reached 42%. A second group of services, those that provide a place to stay and help managing life while homeless, reached between a quarter and a third of respondents. Transitional shelter had been used by 35%, mental health services by 27 %, case management by 26%, and transportation assistance by 24%. Emergency shelter had been used by 18%, peer support by 17%, and substance use treatment by 16%.

Services built to end or prevent homelessness reached fewer respondents. Rapid rehousing, which pairs short-term rental assistance with services to move a person into permanent housing, reached 6%. Services that address specific obstacles to leaving homelessness also reached small shares. Employment or job training reached 9%, and legal assistance 7%. Services for specific populations reached 5% or fewer of the full sample. Domestic violence services reached 5%, child or family services 4%, and youth services 2%. Ten respondents, 6% of the sample, had used no services in the past 12 months.

Several of these figures can be read beside measures of need from the same survey. Forty respondents named domestic violence or an unsafe situation as the first event in their housing loss, a contributing factor, or both. Five of them had used domestic violence services in the past year. Of the 47 respondents looking for work, 7 had used employment services. Of the 34 who cited a criminal record as a barrier to employment, 4 had used legal assistance. Youth services reached 4 of the 26 respondents under 25.

Table 26. Services used in the past 12 months among survey respondents

Services used in the past 12 months (select all)	n	%
Benefits assistance (SNAP, Medicaid, Social Security)	97	60%
Food pantry or meal program	89	55%
Health or medical care	67	42%

Services used in the past 12 months (select all)	n	%
Transitional shelter	56	35%
Mental health services	44	27%
Case management	42	26%
Transportation assistance	39	24%
Emergency shelter	29	18%
Peer support from someone with lived experience	28	17%
Substance use treatment	26	16%
Employment or job training services	14	9%
Legal assistance	12	8%
Rapid rehousing assistance	10	6%
No services in the past 12 months	10	6%
Domestic violence services	8	5%
Child or family services	6	4%
Youth services (under 25)	4	3%

Note. Community member survey Q32, select all that apply (n = 161). Percentages sum to more than 100.

> *"It's [services] not easy to find. They're [service providers are] not always that forthcoming."*
>
> Community Member Listening Session, Salem

9.2 Where People Spend Their Days

The community member survey asked respondents where they spend most of their time during the day. Just over half, 52%, wrote in a location of their own. The most common write-ins were work, followed by home or an apartment, and the shelter. Smaller numbers described a vehicle, a camp, a friend's or family member's place, riding the bus or a bike, or being outside walking, and a few wrote that they were everywhere or nowhere in particular. Among the offered options, parks were selected by 24%, day centers by 20%, and the library by 5%. These results may also reflect that the survey was fielded during the warmer months of the year, May through August. Daytime locations may differ in colder months, when indoor spaces and warming sites are in greater use.

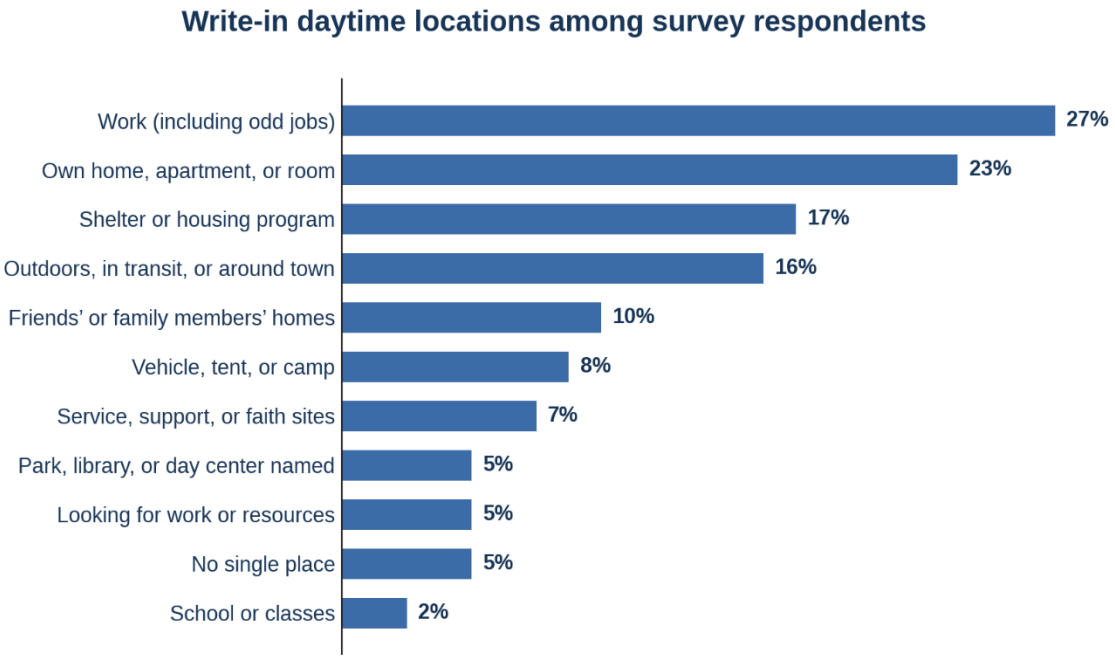


Figure 9. Write-in daytime locations among survey respondents

The write-ins reflect the range of the sample. Respondents who were working, housed, or in a program spent their days at work, at home, or at the shelter. For respondents without those places, the day was spent in public space, with parks as the single most selected location. This finding connects to two others in this report. Only 25 of 44 programs operate around the clock, and day centers are concentrated in Salem, as documented earlier in this report. Therefore, daytime space is limited for people outside those programs and outside Salem. Among respondents who reported safety concerns, 30% cited their neighborhood as feeling unsafe, and participants also describe sweeps and police contact occurring in the same public spaces where people spend the day. Day centers and libraries appear in these responses as daytime places for one in four respondents. In the rural sessions, participants described communities with no day center at all. In Stayton, participants described nowhere to go during the day at all.

9.3 What Has Made the Most Positive Difference

The survey asked respondents what has made the most positive difference for them, with respondents able to select multiple responses. The question responses offered a mix of services, such as food programs and medical care, and relationships, such as a specific worker, family or friends, or a peer with lived experience. **Respondents selected services and relationships alike, with relational supports were among the most frequently chosen.** Figure 10 presents the full distribution, and the table that follows shows how the responses differ by housing situation.

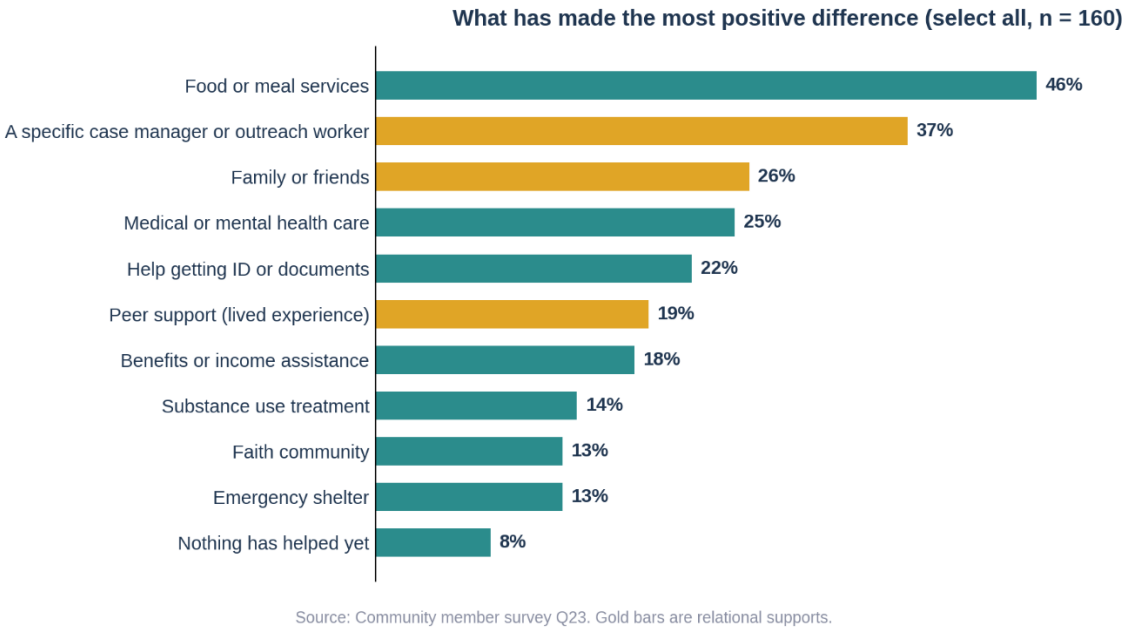


Figure 10. What respondents said has made the most positive difference. The gold bars mark relational supports, a specific case manager or outreach worker, family or friends, and peer support from someone with lived experience.

Food or meal services was the most selected support, at 46%. A specific case manager or outreach worker who helped them was the next most selected, at 37%, ahead of every program category except food. Family or friends was selected by 26%, medical or mental health care by 25%, and help getting identification or documents by 22%. Peer support from someone with lived experience was selected by 19 %, and a faith community by 13%. Thirteen respondents, 8%, reported that nothing has made a positive difference yet. This response was concentrated among unsheltered respondents.

Three of the six most selected supports describe a relationship with an identifiable person rather than a program category. A specific case manager or outreach worker, family or friends, and peer support from someone with lived experience were each selected by between 19% and 37% of respondents. What these three share is that t**he help came from a person the respondent could name, someone who knew their situation and followed it over time.** The remaining supports in the top six categories -, food, medical care, and help with documents - are services a person receives regardless of who provides them. In these responses, the relationship itself was what respondents credited, and it was credited about as often as the services that meet daily needs.

The table below shows the same item by housing situation: unsheltered, sheltered, at risk or doubled-up, and currently housed. Two rows differ most across groups. **A specific case manager or outreach worker was selected by 23% of unsheltered respondents and by 42% to 50% of respondents in the other three groups, rising as housing situations stabilize. Medical or mental health care was selected by 41% of sheltered respondents**

and only by between 11% and 15% by each of the remaining 3 groups. This difference is consistent with shelter programs that provide health services on site or link residents to them. Food or meal services was the most selected support in three of the four groups. Family or friends was selected most often among respondents at risk or doubled up, at 41%, the group most likely to be staying with family or friends.

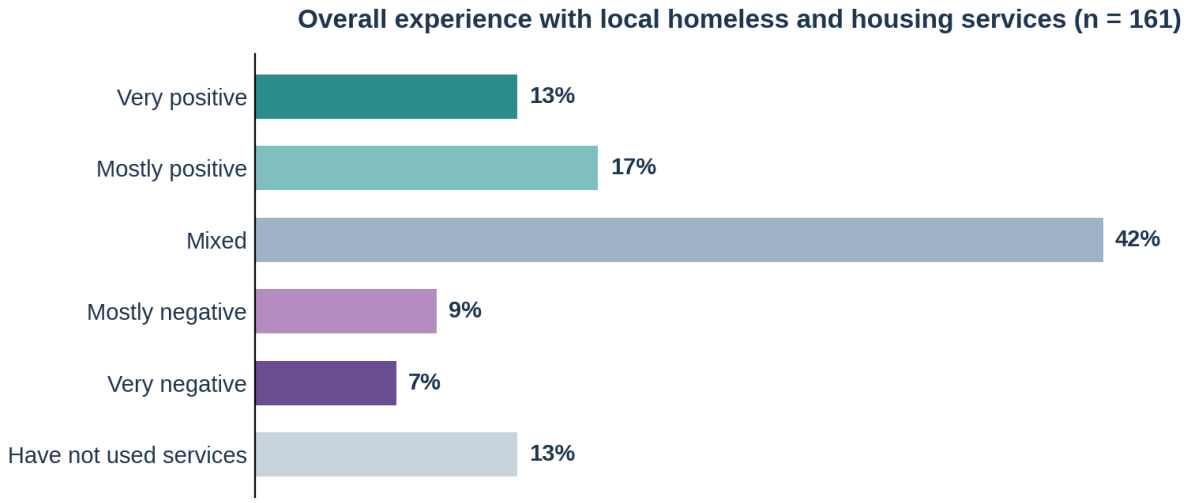
Table 27. What has made the most positive difference, by housing situation

Item	Unsheltered (n=48)	Sheltered (n=64)	At risk or doubled up (n=29)	Currently housed (n=18)
Food or meal services	**48%**	**45%**	**52%**	**33%**
A specific case manager or outreach worker who helped me	**23%**	**42%**	**41%**	**50%**
Family or friends	**25%**	**22%**	**41%**	**22%**
Medical or mental health care	15%	41%	14%	11%
Help getting ID or other documents	25%	23%	14%	22%
Peer support from someone with lived experience of homelessness	13%	23%	17%	22%
Benefits or income assistance	8%	20%	24%	17%
Substance use treatment	13%	9%	17%	22%
Faith community	8%	19%	10%	6%
Emergency shelter (a place where they only allow you to stay for 1 night at a time)	6%	23%	7%	--

Note. Community member survey Q23 by recoded housing situation (n = 159; two respondents could not be classified). Percentages are within each group. Select all that apply, so columns sum to more than 100. Sheltered combines emergency and transitional shelter. At risk or doubled up combines respondents housed but at risk of losing it and those staying temporarily with others. Currently housed refers to respondents recently housed after a period of homelessness. Rows shown are the ten most selected supports overall. A dash indicates no respondents in that group selected the item.

9.4 Overall Experience With Local Services

The community member survey asked respondents to describe their overall experience with local homeless and housing services. **Mixed was the most common response, at 42%**. Thirty percent described their experience as mostly or very positive. Sixteen percent described it as mostly or very negative. Thirteen percent had not used services. **The mixed responses describe experiences that included both help and harm. The same respondents who named specific staff who helped them, described earlier in this section, also named specific staff who mistreated them.** Listening session participants answered a parallel question about how well the system meets their needs. Their answers had the same perspective. Participants expressed gratitude for specific programs and people, and **they described a system that kept them alive without moving them toward housing.**



Source: Community member survey Q39.

Figure 11. Overall experience with local services. Mixed is the median suggesting that most respondents have been both helped and harmed by the same system.

9.5 Peer Support

The survey asked respondents whether they had received support from a peer support specialist, meaning someone with lived experience of homelessness who helps others. Fifty respondents (31%) had received it and found it very helpful. Fifteen (9%) had received it and found it not particularly helpful. Forty-five respondents (28%) had not received it but would like it. Twenty-three (14%) were not sure what peer support is, and 28 (17%) were not interested. **Among respondents who had received peer support, more than three in four found it very helpful.**

The provider survey describes the supply side. **Seventy-three percent of provider organizations employ peer specialists. Seventy percent treat lived experience as a hiring priority or a positive factor.** In the provider listening session, providers with lived experience described peer support as the intervention that changed their own trajectories. They also identified the shortage of peer support specialists as one of the system's primary gaps.

Table 28. Experience with peer support among survey respondents (N= 161)

Experience with peer support (someone with lived experience)	n	%
Received it, and it was very helpful	50	31%
Received it, but it was not particularly helpful	15	9%
Have not received it, but would like it	45	28%
Not interested in this type of support	28	17%
Not sure what peer support is	23	14%

Note. Community member survey Q42 (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100.

> *"[A provider] having the lived experience really changes these clients' paths and makes them see we can recover."*
>
> Service Provider, Listening Session

9.6 Exit Destinations

The provider survey asked where clients most commonly go when they exit programs**. Fifty-six percent of providers reported that most clients exit to permanent housing, and 28%reported exits to permanent supportive housing.** At the same time, 39% reported that clients most commonly return to streets, encampments, or vehicles. Thirty-one percent reported exits to family or friends, and 24% to emergency shelter. Eighteen percent reported that their organization does not systematically track exit destinations. Write-in responses added two destinations the item did not offer, death and administrative exit after a client stops responding. **Among the providers who do track outcomes, 40% track only short-term or point-in-time status. The system's visibility into whether housing placements hold is therefore limited.**

Table 29. Where clients most commonly went at exit, as reported by providers

Where clients most commonly went at exit (select all)	%
Permanent housing	56%
Return to streets, encampments, or vehicles	39%
Family or friends	31%
Permanent supportive housing	28%
Emergency shelter	24%
We do not systematically track exit destinations	18%

Note. Service provider survey Q7, select all that apply (n = 90). Percentages sum to more than 100. Among the 45 respondents who reported tracking outcomes, 40 percent track only short-term or point-in-time status.

9.7 What Providers Say Is Working and Should Be Protected

Providers were asked, in an open-ended item, what is working well. The most common answer, at 17%, was non-congregate and expanded shelter capacity. Providers described micro-shelters, cabins, safe parking, and specific sites. The second most common answer, at 16%, was that the respondent could not name anything or did not know. The low-barrier, Housing First, and trauma-informed practice model was named by 10%. Street outreach and direct agency-to-agency handoffs were each named by 9%, with several providers describing direct handoffs as something to expand. One culturally specific provider described a model already operating in the region. It combines multilingual, culturally specific outreach with housing navigation, flexible rent and utility assistance, landlord coordination, and continued case management, and it reaches refugee, immigrant, and low-income households that other programs do not. **Taken together, the responses describe a small number of practices that**

providers see working, concentrated in shelter models and direct connections between agencies, alongside a sizable share of providers who could not name one.

9.8 The Daily Journey and Community Assets

The listening sessions revealed that much of what sustains people from one day to next is informal. Kinship networks carry a great deal. A grandmother's address serves as a mailing address, a phone number, and a place to charge a tablet. Siblings drive people to job applications. Faith communities function as infrastructure. Participants described laundry vouchers, free dinners, clothing, hygiene bags, and in one case a place to sleep, and they named specific congregations more readily than public agencies. Peer knowledge serves as a referral system. **People who have been unhoused teach newly unhoused people where to go. In three small towns, participants organized their accounts of survival around one named person - a school district liaison, a shelter director, and an outreach coordinator. These relationships determine whether a resource that exists is a resource that can be reached. They also rest on a single person.**

Participants also arrived with skills. Among them were a welder, a cabinetmaker of forty-two years, a professional cook, a carpenter, a landscaper with a local reputation, a former therapist, and a man taking business coursework so he can build a shelter himself. Participants described self-governance arrangements in camps and a wish to contribute that the system rarely has a channel for.

> *"[Good support is] not too smothering. Nor is it holding your hand, and it's not letting you fall."*
>
> Community Member Listening Session, Silverton

KEY TAKEAWAYS – SERVICE UTILIZATION AND WHAT IS WORKING

The services most respondents used were those that meet immediate needs. Benefits assistance reached 60% of respondents, food programs 55%, and medical care 42%. Rapid rehousing, the service most directly aimed at ending homelessness, reached 6%.

Respondents credited relationships about as often as services. A specific case manager or outreach worker was the second most selected support, at 37%, behind only food.

Peer support drew strong ratings from those who had received it. Of 65 respondents who had, 50 found it very helpful. Another 45 respondents wanted it but had not received it.

Providers reported both exits to permanent housing and returns to the street as common. Fifty-six percent reported that most clients exit to permanent housing, and 39% reported that clients most commonly return to streets, encampments, or vehicles. Eighteen percent do not track exit destinations.

Much of what sustains people from day to day is informal. Participants described kinship networks, congregations, peer knowledge, and in three small towns, a single named person around whom their accounts of survival were organized. Each of these supports rests on individuals rather than on a program.

10. Harm, Exclusion, and Avoidance

This section examines whether contact with the service system has caused harm. It presents the survey and listening session findings first, then closes with how those findings relate to the positive experiences reported in this assessment.

10.1 What Has Made Things Harder

The community member survey asked respondents what has hurt or made things harder for them. Respondents were instructed to select all that applied. **Ten percent of respondents reported that nothing had harmed them while 90% selected at least one harm.** Four of the five most selected harms describe experiences with services rather than conditions of homelessness itself. These are separation at program entry, rules, being turned away, and treatment by staff. The fifth, losing belongings in a sweep, describes an experience with enforcement.

Overall, the most selected harm was being separated from family, a partner, or a pet upon entry to a shelter (34%). Rules or requirements that felt unfair or impossible to follow and being turned away from shelter or services were each selected by 31%. Being treated badly or disrespected by staff followed at 28%, and losing belongings during a sweep or eviction at 26%. Feeling unsafe in a shelter or program was selected by 21%, and a program or service that made the situation worse by 17%. Having information shared without permission and invasive questioning were each selected by 13%. Not getting the right help because of race, language, or background was selected by 11%.

Enforcement actions, especially sweeps, result in compound harms that often make the path out of homelessness more difficult. The listening sessions described the enforcement harms in detail. Participants described tents cut open, belongings taken to the dump before a two-hour deadline had passed, work boots and tools lost in a sweep and never replaced, and a $500 citation for a pallet left at a city-designated camping site. Participants in one session also described a drone purchased to locate camps, which they experienced as surveillance of where they slept. One participant lost the equipment required for the job they were trying to keep. These losses are paid for twice. The person loses what was taken. Programs then spend their own resources replacing it, providing new tents, identification, and work gear so the person can start again. In the survey, 37% of respondents homeless 12 months or more had lost belongings in a sweep or eviction, compared with 9% of those homeless for less time.

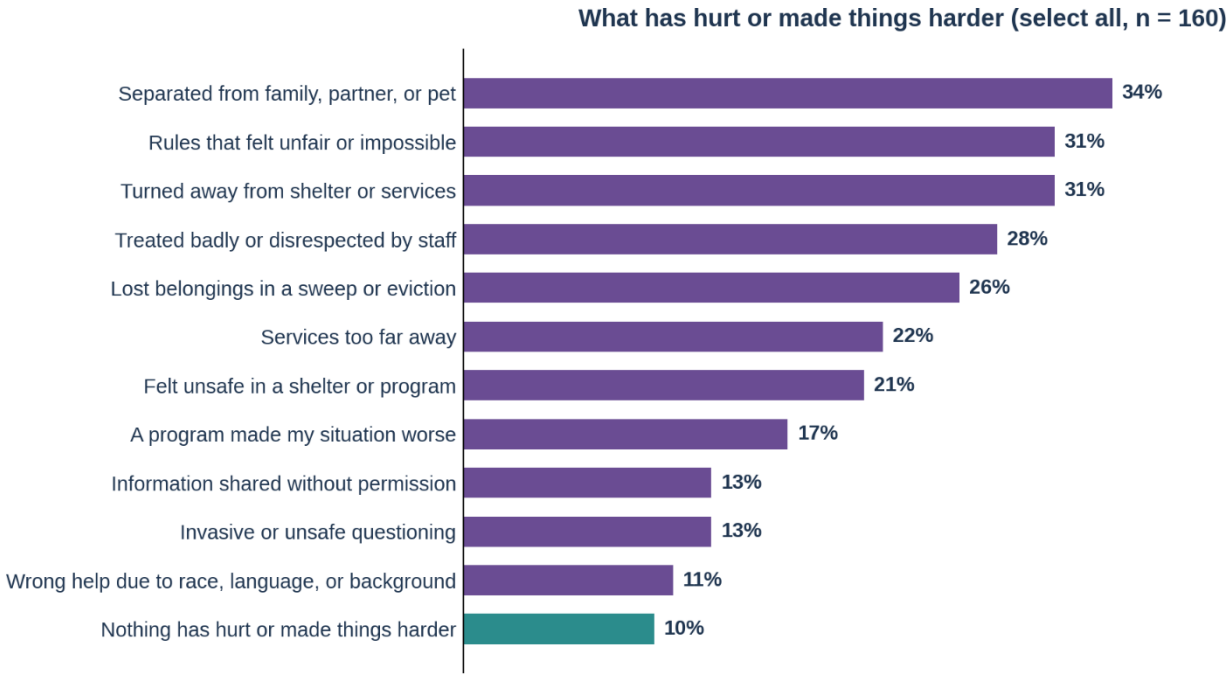
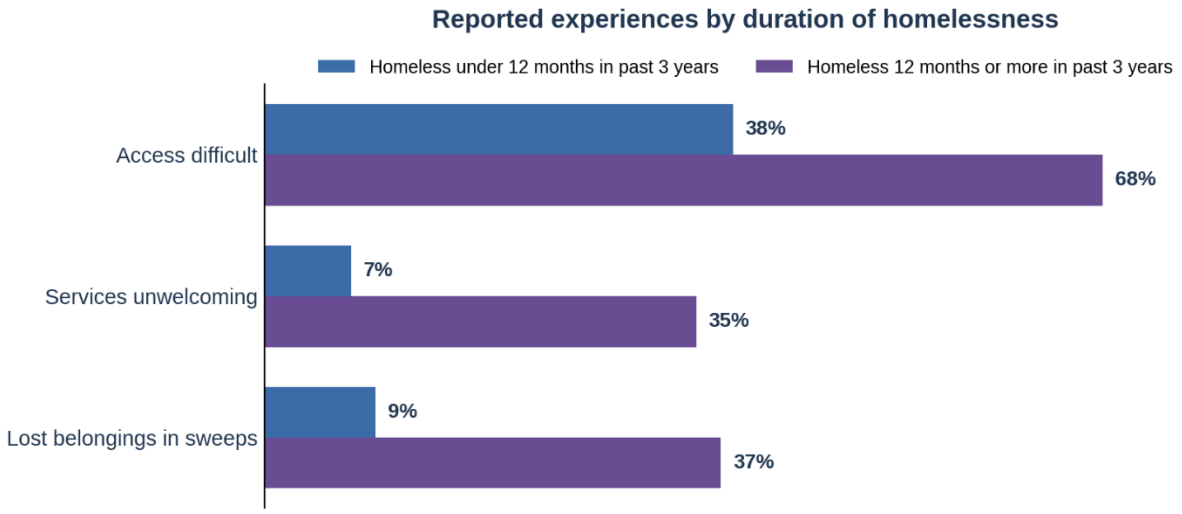


Figure 12. What respondents said has hurt or made things harder. The teal bar marks respondents who reported no harm.

> *"Cops came down there, got him out of the bathroom, told him go get the pallet, get it out of there, or get arrested or get a ticket. He ended up getting a ticket because they wouldn't let him go and load his trailer and get the pallet. There were three cops there."*
>
> Community Member Listening Session, Stayton



Source: Community member survey, among respondents with prior homelessness (n = 103).

Figure 13. Reported experiences by duration of homelessness. Respondents homeless 12 or more months in the past three years are compared with respondents homeless for less time on each measure. Longer experiences with homelessness is associated with worse treatment by the system.

10.2 Denial Based on Identity or Disability

Twenty percent of respondents with a long-term health condition reported being denied services because of their gender identity, sexual orientation, or a disability. Among respondents without a condition, 3% reported the same. The difference is statistically significant. In this sample, disability accounts for most of the identity-based denial reported. The open-ended accounts describe a service dog refused despite documentation, no accommodation for seizures, exclusion linked to ADHD and autism, denial tied to mental health history, and a primary care physician declining both to treat and to refer. Other accounts describe denials tied to gender, race, and recovery status. One respondent, a woman, was turned away from a women's shelter without being given a clear explanation as of why. A different respondent, a man, wrote that men do not get help and are expected to manage on their own. One respondent's race was raised negatively at a service before they were turned away. One respondent had help withdrawn after disclosing that they were in recovery. One account described the consequence rather than the event. The experience made the respondent unwilling to reach out for help again.

10.3 Whether Services Feel Welcoming

Whether services feel welcoming differed by duration of homelessness and by housing situation. Thirty-five percent of respondents homeless 12 months or more said services do not feel welcoming to someone like them, compared with 7% of those homeless for less time. **By housing situation, 34% of unsheltered respondents said services do not feel welcoming, compared with 9% of sheltered respondents.** Positive overall experience was reported by 45% of the shorter-duration group and 16% of the longer-duration group. Young adults reported the opposite pattern. Sixty-three percent found services welcoming, compared with 35% of older respondents. These survey responses indicate that prolonged contact with the system may

accumulate harm. Alternatively, people who experience services as unwelcoming may disengage and remain homeless longer.

10.4 Avoidance

The listening sessions describe how avoidance forms. Avoidance is the behavioral consequence and coping strategy used by people who have been harmed by the system. Participants described that they stopped trying after cycles of being sent from agency to agency, after unexplained denials, after property loss undid months of progress, and after treatment that stripped dignity. In the survey, 11 respondents said they prefer to manage on their own and 8 had not tried to access services.

10.5 What Providers Observe About Trust and Dignity

Providers described the same dynamics from the other side. In the listening session, providers described **three patterns. Clients whose behavior or speech reflects an acute mental health condition** are sometimes treated as difficult rather than as having a disability. **People who have been homeless for years** are sometimes excluded from a program after a relapse or a bad day, with nowhere else in the region to go. **Trust erodes when people on waitlists hear nothing,** or in one provider's words, are forgotten. Provider survey write-ins described the assessment process itself as something clients do not want to be involved with. They also described the absence of any channel through which a person in the coordinated entry pool can learn where they stand. **Providers also observed that engagement language can describe a fit problem. A person described as not ready for services may be facing services that were never built to fit them.**

These findings coexist with the positive experiences this assessment documented. **The same respondents who reported harm also named a specific case manager as the second most credited support, described a shelter as giving people worth, and volunteered for further discussion in 83 of 161 cases. Both accounts are true. The harms reported here were frequent, they followed patterns, and they fell most heavily on people with the longest exposure to the system.**

KEY TAKEAWAYS – HARM, EXCLUSIONS, AND AVOIDANCE

Ninety percent of respondents named at least one harm. **Four of the five most selected harms describe experiences with services, separation at program entry, rules, being turned away, and treatment by staff, and the fifth describes enforcement.**

Disability accounted for most identity-based denial in the sample. Twenty percent of respondents with a health condition reported being denied services because of who they are, compared with 3% of those without one.

Duration of homelessness was associated with worse experience on every measure. Respondents homeless 12 months or more reported more difficulty accessing services, less welcome, and four times the rate of property loss in sweeps.

The harms reported here coexist with valued help from the same system. Both accounts came from the same respondents. The harms were frequent, they followed patterns, and they fell most heavily on the people with the longest exposure to the system, which makes them measurable as a feature of the system rather than as isolated accounts.

11. System Capacity, Practice, and Infrastructure

This section examines the service system itself. It draws primarily on the provider survey, the provider listening session, and infrastructure findings from the landscape scan. It begins with demand and capacity, then turns to the workforce, and then to the infrastructure through which programs connect to one another and to the people they serve.

11.1 Demand and Capacity

Eighty-four percent of providers reported that demand for their services increased over the past 12 months, and 52% reported a significant increase. Only one provider reported a decrease. Providers described their capacity to meet that demand in three ways. Thirty-two percent reported that demand exceeds their capacity. Fifty-three percent reported meeting most, but not all, of the demand for their services. Fourteen percent reported fully meeting demand. Seventy-seven percent of providers maintain a waitlist, either a standing list (47%) or one that opens when capacity is reached (30%).

How long people wait cannot currently be measured across the system. Providers were asked, in an open-ended item, what a typical wait time is. Of the 66 who answered, 46% gave a figure that fits a time band, as indicated in the chart below. Twenty-three percent said it varies and gave no figure. Seventeen percent did not know. **Answers ranged from fifteen minutes to more than two years.** One organization reported internal waitlists ranging from 300 to more than 3,000 people across its sites. The responses show no shared understanding across the region of what a wait time is or how it is counted. Without one, the system cannot measure its own performance on waiting, and it cannot tell a person seeking help how long they will wait.

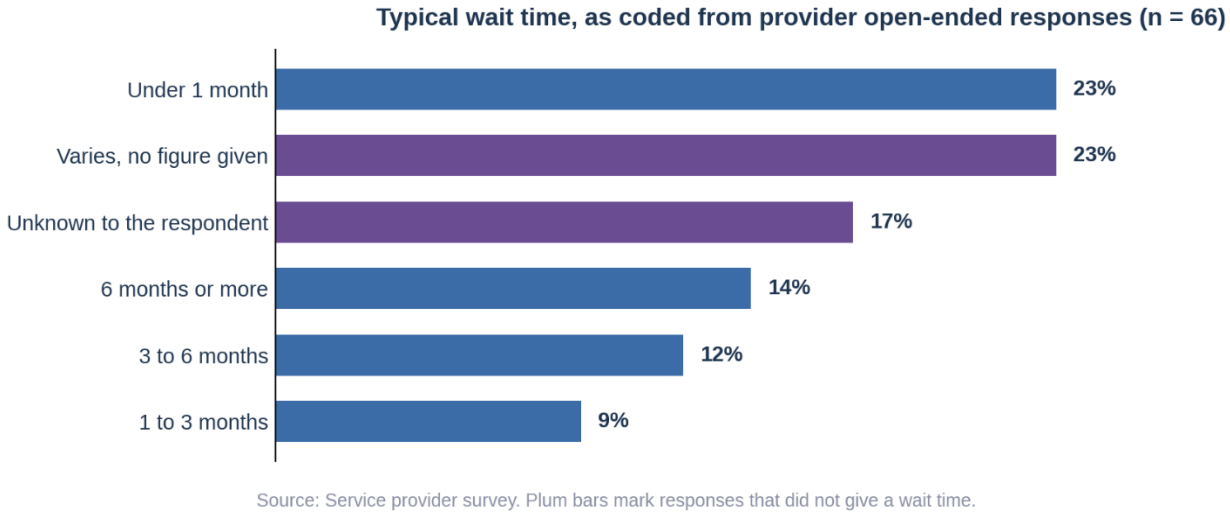


Figure 14. Typical wait time, as coded from provider open-ended responses. The plum bars mark responses that did not give a wait time.

11.2 Workforce

Providers were asked to select their greatest workforce and staffing challenges. **About half of the providers reported funding that does not cover adequate staffing levels.** Among leadership respondents, that share rose to 77%. Forty-four percent named burnout and secondary trauma. Wage competitiveness followed at 30%, and difficulty retaining bilingual or multilingual staff at 20%, in a region with a substantial agricultural and Spanish-speaking population. Nineteen percent reported that staffing is not a significant challenge for them. Difficulty finding qualified employees was named by 16%, and difficulty recruiting staff with lived experience by 13%. In these responses, providers most often described the constraint as the funding and conditions that sustain staff rather than the availability of people to hire.

Table 30. Greatest workforce and staffing challenges reported by providers

Greatest workforce and staffing challenges (select all)	%
Funding does not cover adequate staffing levels	50%
Burnout and secondary trauma	44%
Wage competitiveness	30%
Difficulty retaining bilingual or multilingual staff	20%
Staffing is not a significant challenge for us	19%
Difficulty finding qualified employees	16%
Difficulty recruiting staff with lived experience	13%

Note. Service provider survey, select all that apply (n = 90). Percentages sum to more than 100. Among leadership respondents, the funding item was selected by 77 percent.

> *"Many people who apply to do this work could almost be our clients. Their own stability is often very shaky, health is often poor, and call offs are common, making coverage a challenge, and creating burn out of the staff who can reliably fill in."*
>
> Service Provider, Listening Session

A workforce drawn substantially from people with lived experience of homelessness and housing precarity brings that experience to the work. It also carries staffing consequences. Providers in the listening session described the supports this workforce needs, including coverage depth, supervision, wellness support, and paid self-care time built into scheduled hours. One respondent named the frontline workforce itself as a population falling through the cracks. This hiring practice is otherwise established throughout the region. **Seventy percent of providers treat lived experience as a hiring priority or a positive factor, and 73% employ peer specialists.**

11.3 Language and Interpretation Capacity

The provider survey asked about interpretation capacity. Eighty-six percent of provider respondents reported their organization has some capacity to provide interpretation services for clients. Forty-eight percent reported formal capacity, through in-house or contracted interpreters or remote interpretation services. Twenty-nine percent reported limited and informal arrangements, including bilingual staff and clients' family members. Family-member interpretation raises confidentiality and accuracy concerns, particularly for domestic violence and behavioral health disclosures. Fourteen percent reported no interpreter capacity.

Organizations with formal interpretation capacity reported language as a client barrier about half as often as organizations without it. On a separate item, both groups reported at similar rates that services feel unwelcoming to clients because of their identity or culture. Having interpreters was associated with fewer language barriers, but not with clients feeling more welcome. The two are different problems.

Bilingual capacity was measured twice in this assessment, once in the provider survey and once in the landscape scan, and the two measures ask different questions. The provider survey asked respondents from all organization types about interpretation arrangements. It found 29% with an in-house interpreter on staff and 48% with formal interpretation capacity of any kind. The landscape scan asked the 44 sheltering programs about bilingual staffing. It found about 55% of programs with bilingual Spanish staff or advocates and as many as 75% offering Spanish in some form. Beyond Spanish, coverage thinned. Russian was available at four programs, sign language at three, Marshallese at two, Chinese and Vietnamese at one each, and Chuukese at none.

Table 31. Interpretation capacity among provider respondents (N = 90)

Interpretation capacity (provider survey)	N	%
In-house interpreter on staff	26	29%
Limited and informal arrangements (bilingual staff, family members)	26	29%
Contracted or on-call interpreters	17	19%
No interpreter capacity	13	14%
Telephone or remote interpretation	8	9%

Note. Service provider survey Q3, select all that apply (n = 90). Percentages sum to more than 100. Formal capacity combines in-house, contracted, and remote interpretation.

11.4 Harm Reduction

In this report, harm reduction refers to substance use. It means reducing the negative consequences of substance use without requiring abstinence as a condition of service. Harm reduction is near-universal in principle and narrow in practice. Eighty-three percent of providers reported using harm reduction approaches. Fifty-two percent described it as a core philosophy and formal practice. Four percent reported an abstinence-based program model, meaning a

program that requires clients to abstain from drugs and alcohol as a condition of service. When asked which specific practices they offer, providers reported a narrower set of options. For instance, naloxone distribution was reported by 68% and peer support from people with lived experience of substance use by 54%. Every other practice was reported by roughly a quarter of providers or fewer. Fentanyl test strips were reported by 26%, MAT linkage by 23%, non-judgmental substance use counseling by 23%, overdose prevention education by 22%, wound care without sobriety requirements by 16%, and syringe services by 4%.

Harm reduction in this region largely means naloxone plus a non-judgmental stance. When providers were asked what prevents their organization from implementing or expanding harm reduction practices, the most common answer, at 44%, was that they did not know what was preventing broader implementation. Among those naming a barrier, funder restrictions and lack of staff training were each named by 20%, liability concerns by 19%, and uncertainty about the legal status of harm reduction tools in Oregon by 10%. Two providers wrote in a constraint the item had not offered. Their organizations share a site with a partner agency that operates an abstinence-based program, and the shared location limits the harm reduction practices they can offer there.

The landscape scan adds the bed-level perspective. **Two-thirds of sheltering programs use a behavior-based approach to substance use, meaning they respond to behavior on site rather than requiring sobriety or testing for it. Seven programs, about one in six, take the strictest approach, requiring abstinence from drugs and alcohol and verifying it through drug testing.** A person in these programs must be sober to stay, and a failed test can mean losing the bed. Those seven programs account for roughly 391 beds, about 27% of the system's total, because they include the region's two largest single-gender congregate shelters. The beds behind the strictest requirement are also among the most congregate and least private, with large shared sleeping areas rather than rooms. For a person who cannot or will not meet an abstinence requirement, more than a quarter of the beds counted in the region's capacity are not usable, and a count of total beds overstates what is available to them.

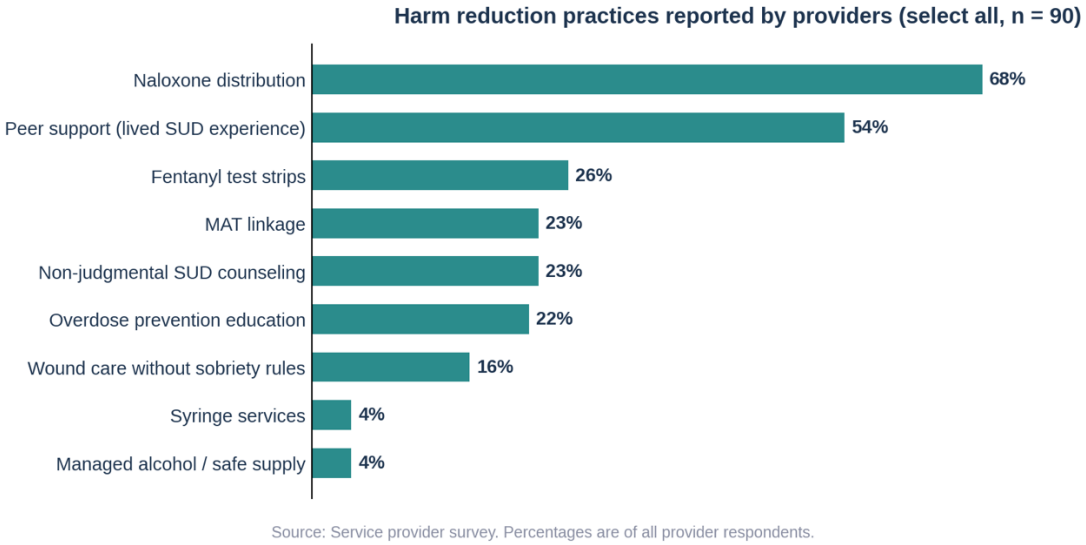


Figure 15. Harm reduction practices reported by providers.

11.5 Coordinated Entry

Coordinated Entry is the process through which people are assessed, prioritized, and referred to housing and homeless assistance across the region.[18] Federal rules require each Continuum of Care to operate one. Programs funded through the Continuum of Care and through Emergency Solutions Grants must use it. Victim service providers may choose not to, to protect survivors' confidentiality. Other programs may take part voluntarily. Coordinated Entry does not work as a first-come, first-served list. People who are assessed enter a pool and are prioritized for openings by need and vulnerability, under the Continuum of Care's written standards. HUD requires a standardized assessment but does not name a specific tool. The landscape scan found Coordinated Entry in use at 18 of 44 sheltering programs, most of them low-barrier. The provider survey asked about participation in it, its effectiveness, and its gaps.

Overall, provider participation in coordinated entry is high. Seventy-nine percent of providers participate in some capacity, and 69% conduct assessments as an access point. Not one of the 90 provider respondents selected the option that Coordinated Entry is working well. The single largest response, at 38%, was that the respondent does not have enough visibility into the system to assess it. Among providers who participate, 68% identified insufficient housing and programs to refer to as the biggest gap. Poor communication about referral status followed at 39%, prioritization criteria that exclude high-need individuals at 31%, and a system not well understood by providers or clients at 30%. On assessment tools, 37% reported using the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT).[19] Twenty-three percent reported using an assessment tool without knowing which one. The Coordinated Entry assessment is the one that places a person in a regional pool. Other tools may be used by individual program for their own intake.

Write-in responses described four gaps. The assessment relies on client self-report, with no way for a worker's observation to inform the score. Clients placed in the Coordinated Entry pool have no channel to check where they stand. And some clients do not want to be involved with the system at all. Providers in the listening session described Coordinated Entry as a labyrinth and described assessments that never appear in the system. The missing status channel adds to the communication finding. The communication gaps providers described run not only among agencies but between the system and clients, who are told to wait and then have no way to ask where they stand.

Overall, the findings describe two kinds of gaps at once. Sixty-eight percent of participating providers selected insufficient housing and programs to refer to. The item did not distinguish programs that do not exist from programs that exist but cannot be reached through Coordinated Entry. The landscape scan found Coordinated Entry in use at 18 of 44 sheltering programs, and the region's two domestic violence shelters operate outside HMIS. A shortage of programs to

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[18] U.S. Department of Housing and Urban Development. (2017). Notice establishing additional requirements for a Continuum of Care centralized or coordinated assessment system (CPD-17-01). 24 CFR § 578.7(a)(8). 24 CFR § 576.400(d).

[19] Brown, M., Cummings, C., Lyons, J., Carrión, A., & Watson, D. P. (2018). Reliability and validity of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) in real-world implementation. *Journal of Social Distress and the Homeless, 27*(2), 110–117. https://doi.org/10.1080/10530789.2018.1482991

refer to can therefore reflect limited inventory, limited inventory connected to Coordinated Entry, or both. Providers also identified gaps in the process itself, in how assessments are conducted, whether they reach the system, and how clients learn where they stand.

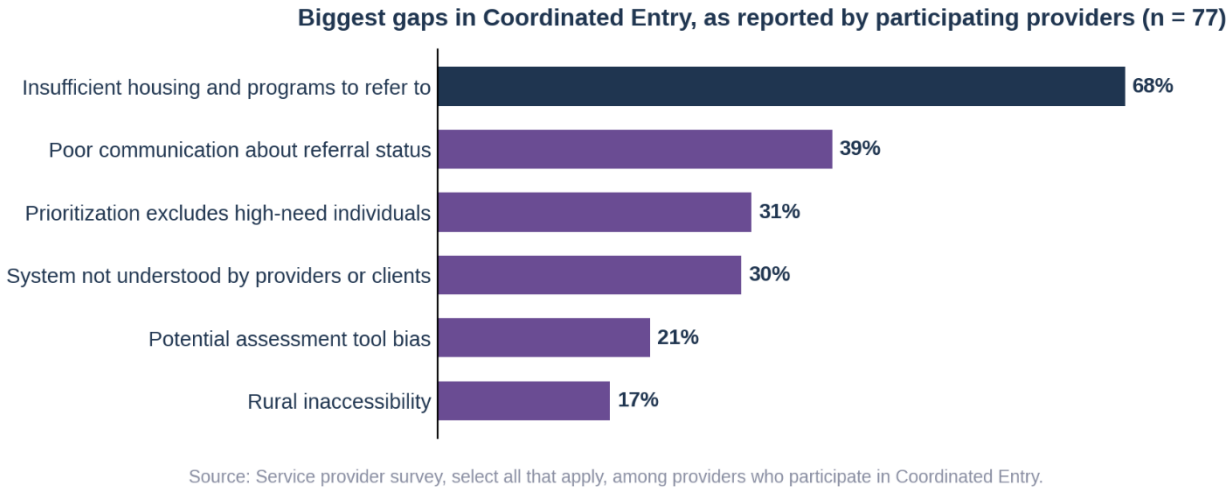


Figure 16. Biggest gaps in Coordinated Entry, as reported by providers who participate in it. The navy bar marks insufficient housing and programs to refer to, the most selected gap.

The findings describe two distinct gaps. Providers identified a shortage of housing and programs to refer to, and they identified gaps in the process itself, in how assessments are conducted, how reliably they enter the system, and how clients learn where they stand. The two kinds of gaps are distinct. A referral process routes people to what exists, so more inventory would not by itself repair the process gaps, and a repaired process would still be routing people toward the same limited inventory. The provider responses locate the larger gap in inventory, selected by 68%, while the process gaps together were named by substantial shares.

11.6 Referral Practice

Sixty-six percent of providers maintain an active referral network and regularly connect clients to organizations beyond their own. The listening sessions described what happens when the work of coordination loses funding. Providers described an organization that, after a grant cut, eliminated the meetings where agencies exchanged information about programs and openings. Without those meetings, staff knowledge of other programs went out of date. Clients were sent to programs that could not serve them, which cost the client's time and the receiving agency's time. Providers described calling shelters listed online as having open beds and being told the beds had been full for four months.

11.7 Coordination

The provider survey asked two questions about coordination, how well organizations currently work together and what stands in the way of working together more effectively. On the first, ratings fell mostly in the middle of the scale. Forty-six percent of providers rated coordination as working fairly well with gaps. Thirty-two percent rated it inconsistent. Twelve percent rated it very well, and 10% rated it poorly.

On the second, the most named barriers concern the structures through which coordination happens. **Inadequate communication structures were named by 51% of providers. Insufficient staffing capacity to coordinate followed at 47%, lack of shared data systems or agreements at 46%, and unclear roles across agencies at 40%. The barriers that describe relationships between organizations were named least often.** Turf conflicts were named by 21%, geography by 19%, and lack of trust between organizations by 13%.

Table 32. Barriers to more effective coordination reported by providers (N = 90)

Barriers to more effective coordination (select all)	%
Inadequate communication structures	51%
Insufficient staffing capacity to coordinate	48%
Lack of shared data systems or agreements	46%
Unclear roles across agencies	40%
Competing funding requirements	32%
Turf conflicts	21%
Geography	19%
Lack of trust between organizations	13%

Note. Service provider survey, select all that apply (n = 90). Percentages sum to more than 100.

Providers also reported that they do not know what services and support their peer organizations actually offer, how similar providers differ, or when program offerings change. On formal data sharing, 47% of providers did not know whether their organization has agreements at all. Among those who knew, the most common partners were MWVCAA and ARCHES, at 31%, and the Continuum of Care, at 28%. Agreements with hospitals were reported by 9%, with county government by 8%, and with criminal legal partners by 4%. Providers named release from jail or prison among the most common circumstances their clients share, and few reported formal agreements with the institutions involved. In these responses, providers located the barriers to coordination in structures, staffing, and shared information rather than in the relationships between organizations.

11.8 Discharge Planning

A third of providers reported a formal discharge planning protocol of their own. In the listening session, providers described warm handoffs that happen informally, between individual staff who know one another. They described discharges from hospitals, jails, foster care, and behavioral health facilities arriving without housing in place, and no formal handoff agreements with the discharging institutions. Nearly half of providers named institutional release among the circumstances clients most commonly share. Four percent reported data-sharing agreements with criminal legal partners, and 9% with hospitals. The system currently identified institutional discharge as a major inflow while holding almost no formal relationship with the institutions producing it.

11.9 Data Infrastructure and Learning Systems

Seventy-three percent of provider respondents use HMIS. Write-in responses identified at least nine distinct platforms in active use alongside it, including spreadsheets at 42%, custom databases, electronic health records, and named systems such as Activate Care and Need Navigator. The landscape scan shows the inventory side. Thirty-one of 44 sheltering programs participate in HMIS and 13 do not. Two of those 13 programs are outside HMIS by design. Federal confidentiality rules prohibit victim service providers from entering client data into HMIS, so the region's two domestic violence shelters record required data in a separate comparable database. HMIS deduplicates at the county level but not the program level. The region therefore cannot produce an unduplicated count of who its shelter system reaches each year. The sum of program-reported unique individuals served, 8,345 across the 28 programs reporting, measures scale rather than distinct people.

Providers rated their own data quality fairly positively, and the data they collect covers a narrow range. Basic demographics are collected by 83% and housing status at intake and exit by 72%. Client satisfaction or feedback is collected by 23%. Disaggregated outcome data by race is collected by 13%. Fifty-one percent of providers did not know whether their organization has ever reviewed outcomes by race or ethnicity, and among frontline staff the figure was 57%. Training on racial equity analysis was the least selected infrastructure request, at 14%. One respondent described what such analysis produced at their organization. The respondent compared guest demographics against county census figures, found under-service of Hispanic residents and over-representation of Native American, Black, and Pacific Islander guests, and documented that older women were referred away because the shelter lacked lower bunks and 24-hour operation.

11.10 Organizational Capacity Constraints

The provider session described funding losses in concrete terms. A peer-run recovery center reported a 78% loss in funding. It is no longer open seven days a week, and its hours dropped from 10 a.m. to 5 p.m. to 11 a.m. to 4 p.m. Another provider whose position is funded through the Behavioral Health Resource Network, the Measure 110 program, reported a 12% cut to that grant in the past year. That provider described quarterly meetings among the network's 11 grant partners in the community. Because of funding, those meetings have been cut back to once a year. Providers connected that sequence to referral knowledge going out of date.

The survey shows differences between leadership and frontline staff on several measures. Leadership and frontline staff see different systems. Leadership respondents track client outcomes at 68%, compared with 21% of frontline staff. Leadership rated Coordinated Entry negatively at 55%, compared with 16% of frontline staff, and 46% of frontline staff reported that they cannot see the system well enough to rate it. Leadership named funding as the staffing constraint at 77%, compared with 41% of frontline staff.

Frontline staff are not more positive about the system. **Within the frontline group, 90% of outreach workers did not know whether their own organization employs peer specialists, and more than 80% of peer and community health workers do not track outcomes. These are the staff with the most direct contact with unsheltered people and the least**

connection to the system's information. Organizations outside Coordinated Entry were roughly twice as likely to name single women as a population falling through the cracks, and more likely to identify geographic distance and shelter safety as barriers.

Program type divides the sample a third way, between shelter and housing programs, which provide places to stay, and non-housing programs, such as day centers, outreach, behavioral health services, and food programs, which serve people without providing housing. Shelter and housing programs carry waitlists at 54%, compared with 26% of non-housing programs. Non-housing programs reported less visibility into Coordinated Entry, at 57% lacking it compared with 31%, and no non-housing respondent rated regional coordination as working very well.

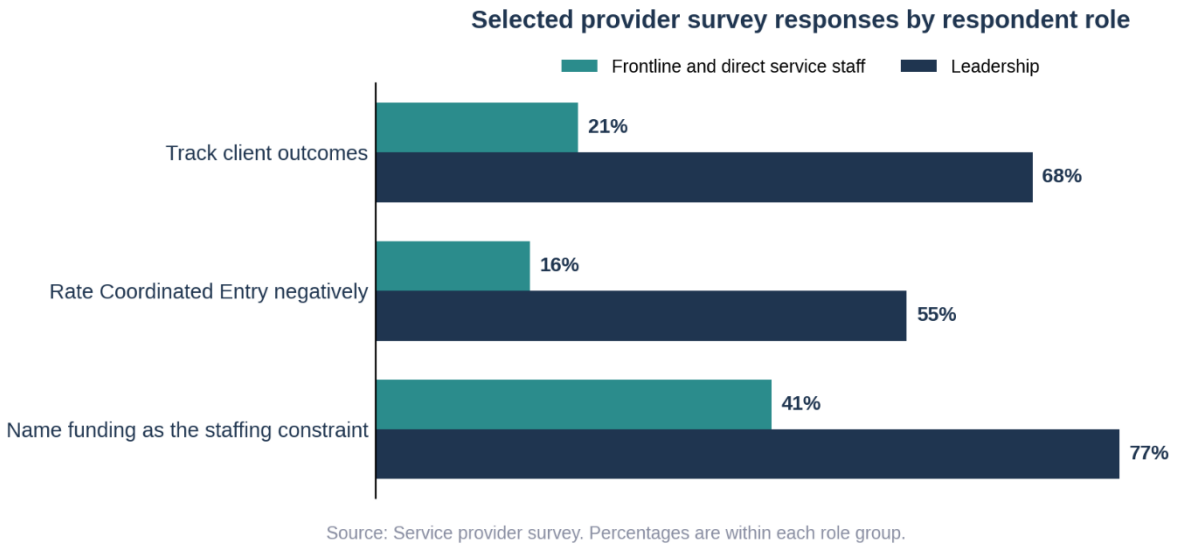


Figure 17. Selected provider survey responses by respondent role. Leadership and frontline staff differ on each measure shown.

11.11 What a Functioning Regional System Would Require

Across this section, provider responses converge on five kinds of infrastructure that the region does not currently have. The **first is shared definitions,** beginning with what counts as a wait time and what low barrier means in operation. Without shared definitions, measures cannot be compared across providers. The **second is a shared and current information layer, a directory of capacity and eligibility that records changes, visible to providers** and in simpler form to the public. **Both surveys found not knowing what exists to be among the largest barriers.** The **third is communication channels that reach clients**, including a way for a person on the Coordinated Entry list to learn where they stand and notification by more than postal mail. The **fourth is analytic capacity that organizations can share**, enough to produce an unduplicated count and to analyze outcomes by race, since thirteen programs sit outside HMIS and nine platforms are in use. The **fifth is funding structured for the work, as providers described it -** covering staffing, coordination time, and flexible assistance. The recommendations in this report return to each.

KEY TAKEAWAYS – SYSTEMS CAPACITY, PRACTICE, AND INFRASTRUCTURE

Demand for services is rising. Eighty-four percent of providers reported increased demand and 77% carry a waitlist, and fewer than half of providers answering could state a typical wait time.

Funding is the workforce constraint, and the lived-experience workforce that is one of the region's genuine strengths needs coverage depth and paid self-care.

Coordinated Entry received zero endorsements from 90 respondents. Two-thirds of participants say the core problem is nothing to refer to; assessment validity, fidelity, and a missing client status channel are the process defects that would persist even with inventory.

H**arm reduction is broad but shallow, and more than a quarter of the region's beds sit behind the strictest sobriety requirements**

Race is recorded at intake at six times the rate it is analyzed against outcomes, and 51% of providers did not know whether their organization has ever reviewed outcomes by race or ethnicity.

Leadership and frontline staff answered differently on outcomes tracking, Coordinated Entry, and staffing constraints, and the **staff with the most direct contact with unsheltered people reported the least connection to the system's information.**

12. Populations Requiring Targeted Approaches

The findings in this report so far describe the population as a whole. This section examines the groups within it whose circumstances, pathways, or service needs differ. Each subsection follows the same structure. It presents what the survey data show where sample sizes permit, what listening sessions and providers described, and what the services the landscape reported for that population.

12.1 Families With Children

Parents of minor children reported more difficulty than other respondents on several measures. Sixty-five percent cited long waitlists, compared with 35% of respondents not parenting. Sixty-three percent did not know what services were available, compared with 42%. **Fifteen percent described their overall service experience as positive, compared with 40%.** Parents also reported feeling unsafe in shelter at higher rates. **Eighty percent of parents named permanent housing as a top need, the highest share for any subgroup on any needs item in the survey.** Childcare appeared both as an unmet need and as an employment barrier. Fifteen surveyed parents did not have their children with them.

The landscape scan describes the family capacity behind these figures. Family capacity is weighted toward longer-term programs with low turnover. Dedicated emergency family shelter holds seven household units, and five family units were open at the time of the scan. Family intake often runs through appointment-only or business-hours processes, so a family in crisis on a Friday evening has limited pathways until the next business day. Providers described two design gaps. Few shelters serve fathers with children. The ARCHES Nest is the only family shelter in the region that accepts fathers with children. Few facilities serve two-parent families.

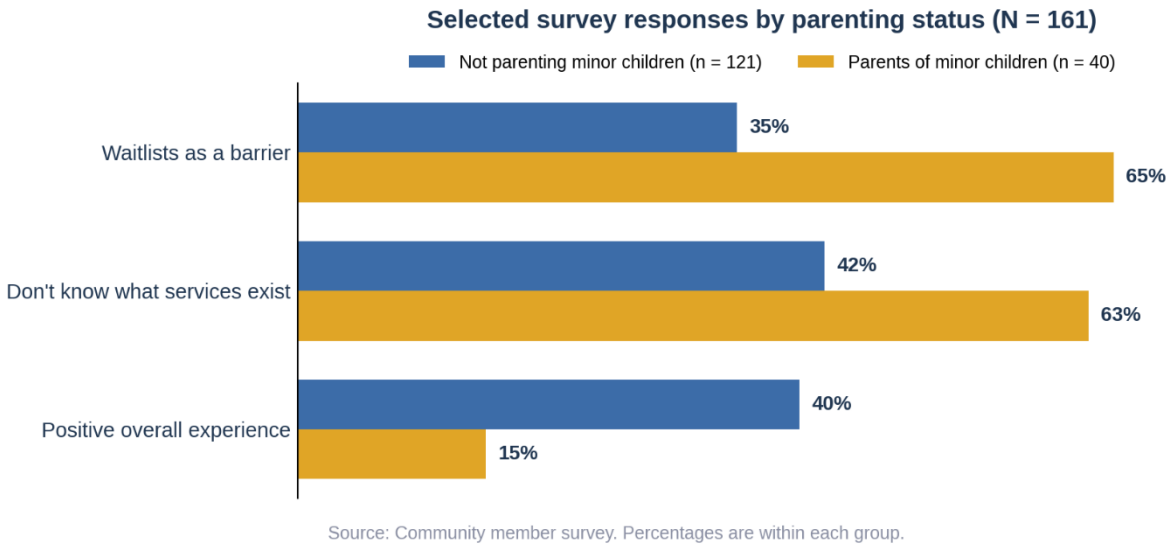


Figure 18. Selected survey responses by parenting status.

12.2 Youth and Young Adults Under 25

Young adults reported easier access and more welcome than older respondents, with 72% finding services easy to access. They were also the lowest-income group in the sample, with 87% living on under $500 per month. Youth programming may be more relational and less rule-bound, or younger respondents may simply have had less exposure to the system, since reported experience worsens with duration. The listening sessions described the youth pathway as family rupture, with participants entering homelessness at 13, 15, and 17 years of age, sometimes tied to issues with their identity or safety at home. One young survivor of family violence was refused by multiple domestic violence shelters because his abuse was not intimate-partner violence.

In addition, the dedicated infrastructure to support youth and young adults is limited. The region holds 20 dedicated youth beds, about 1.4% of all beds. These beds are located in two ten-bed houses. A Salem day center serves youth during daytime hours only. All three facilities are in or near Salem, and none is in rural Marion County. Young adults 18 to 24 are generally served within adult programs. In the youth session, young adults described the cost of replacing identification as the barrier standing between them and work. A replacement identification card costs money, employment requires the card, and without work there is no money to replace it. Several young adults described this loop as what kept them from working.

12.3 Older Adults 55 and Over

Older adults were the population providers most often described as growing and falling through the cracks in the system. The shift toward adults 65 and over was the most common household-mix change providers reported, at 21%, and older adults ranked second among populations providers identified as falling through the cracks, at 59%. A third of listening session participants were 55 or older. These participants described rent increases, layoffs, divorce, and medical events late in a working life, and the physical cost of years outside.

In the survey, 29 respondents were aged 55 or older. Among them, 12 were staying in shelter or transitional programs and 6 were unsheltered, with the remainder in other situations including housed but at risk. Sheltered or not, older participants described the physical toll of homelessness accumulating faster for them than for younger people. Sleeping outside or in a vehicle, walking between services, carrying belongings, and going without consistent medical care wear on bodies already managing the conditions of later life, and participants described injuries and illnesses that did not heal as they once had. One Monmouth participant described years of living outside had on his health.

> *"Two years ago I was a hundred times healthier than I am now."*
>
> Community Member Listening Session, Monmouth

12.4 Latinx Community Members and Farmworkers

Nearly half of provider respondents serve Latinx community members, and a third serve farmworkers. No sheltering program in the region is designed specifically for the Latino

community. Culturally specific and language services ranked near the bottom of provider-observed needs. One case manager wrote that the Latino community is struggling because of fear of immigration enforcement and lack of cultural understanding.

12.5 Rural Residents

The landscape scan shows Polk County holding 4.4% of regional capacity with no day or resource center anywhere in the county, and rural Marion holding scattered single programs. The listening sessions described services and infrastructure absent altogether, no laundromat or grocery store in Falls City, no day space or shower in Stayton, a warming center that opens only at 34 degrees or below for three consecutive days with volunteer staffing, and mail-dependent paperwork in communities with unreliable delivery. The survey shows respondents outside Salem less likely to have been turned away, consistent with fewer programs to approach. Participants described the rural service delivery they sought. They asked for mobile services on a scheduled and publicized route, day space in their own communities, laundry access, and transportation. They described these as alternatives to being directed to Salem.

Rural participants also described the impact of living in a small town and being known for being homeless. In a town where six people sleep outside, residents know who they are. Participants described what this brings them and what it costs. Neighbors and congregations help because they know you. At the same time, there is no anonymity, and a person's circumstances are visible to everyone.

> *"There's so few of us that it's easy to get to know us and put our picture on Facebook."*
>
> Community Member Listening Session, Stayton
>
> *"This is a perfect example of why some of us are uncomfortable admitting that we're homeless, because the homeless are getting blamed for everything. Some of us are flat out lying about having an apartment when we don't, just because we understand the struggle, how real it is, and the harassment that comes associated with the stigma."*
>
> Community Member Listening Session, Monmouth

The concealment participants described has a consequence for the numbers reported on the level of homelessness in the region. **People concealing their homelessness to avoid stigma are undercounted by every enumeration method this assessment draws on, so rural prevalence figures are best read as minimums. Concealment also bears on engagement. A person concealing the circumstance is unlikely to approach a service labeled as serving that population.**

Participants also described the label itself as something they did not accept. Some preferred "houseless," a term with real currency in the region, describing their circumstance as being without a house rather than without a home. Others rejected any category term. One Stayton participant, unhoused on and off since 1984, asked to be rid of the word altogether.

"I'd like to get rid of the name homeless. I don't want to own it. I am just want [his name]. I'm not homeless. I don't want to be known by that."

Community Member Listening Session, Stayton

A provider at a day resource center described encountering the same distinction from the other side, clients who told him they were not "these kinds of homeless." **The distinction people draw between being homeless and being without a house is not wordplay. "Homeless" arrives carrying an identity, with the stigma participants described attached to it. "Without a house" describes a circumstance, something a person is experiencing rather than something a person is. Participants who drew the distinction were declining the identity while acknowledging the circumstance.** For services, the two framings behave differently. **A service framed around the identity asks a person to accept the label as a condition for receiving services. A service framed around the need, such as laundry, mail, a shower, help with rent, asks nothing about identity at all.**

12.6 People With Disabilities and Chronic Health Conditions

This is the largest population in the assessment by any measure. Three-quarters of survey respondents reported a long-term condition. Forty-three percent of listening session participants identified as a person with a disability. Providers ranked people with disabilities third among populations falling through the cracks, at 56%. Respondents with a condition were seven times more likely to report identity-based denial, with accounts including a refused service dog and absent seizure accommodation. Forty respondents were unable to work due to disability or health, and 26 received SSI or SSDI, with open-ended accounts describing multi-year application backlogs. The landscape scan found physical accessibility affirmatively reported at 12 of 44 programs, with 32 not reporting, so the system cannot say how many beds a person with a mobility disability can use. Deaf participants described a further layer, services and community spaces without interpretation, and communication disability being conflated with cognitive capacity.

12.7 People With Behavioral Health Needs and Substance Use Disorders

Serious mental illness led the populations providers identified as falling through the cracks, at 71%, with substance use disorders at 56% and dual diagnoses at 49%. Frontline staff named substance use disorders more often than leadership. Mental health services topped provider-observed needs at 80%. More than a quarter of the region's beds sit behind abstinence-with-testing requirements. Providers named congregate settings as a relapse risk. Providers described people in acute mental health crisis whose symptoms, such as agitation, loud or rapid speech, or difficulty following a conversation, are interpreted by staff as aggression rather than as signs of illness. Providers also described chronically homeless people excluded after a relapse or a bad day with nowhere else in the region to go. In the provider needs data, substance use treatment and dual diagnosis support were each named less often than

substance use. The provider needs data show a related pattern. Providers reported mental health and substance use conditions occurring together across their caseloads, and they named dual diagnosis support, the service built to treat both at once, less often than they named treatment for either condition alone.

12.8 Gender: Two Different Poverties

The community survey shows differences by gender. Fifty-one percent of men reported no income at all, compared with 30% of women. Women were more likely to have some income, consistent with the benefit receipt that accompanies having children in care. The journey and pathway to becoming homeless differed by gender. Women identified domestic violence or an unsafe situation as a contributing factor at 23%, compared with 7% of men. Women cited mental health challenges at 39% compared with 21%, physical health at 25% compared with 10%, and rent unaffordability at 45% compared with 27%. Women were more likely to have a pet, at 56% compared with 27% of men, and named rent and deposit assistance as a top need at roughly twice the rate of men.

Men, by contrast, were the sample's lowest-income group and reported the fewest connections to services. In the provider survey data, men appear repeatedly among the populations existing programs do not fit. Providers described shelters for women and children but not for men with children, single adults and single fathers among those falling through the cracks, and the two largest men's congregate facilities carrying the region's strictest sobriety requirements. Individuals who were non-binary cited family breakdown at 64% (7 of 11) and discrimination as a contributing factor at 36% (4 of 11), compared with 6% of women and 3% of men.

12.9 Survivors of Domestic Violence

Domestic violence or an unsafe situation was the first event that started the path to housing loss for 12% of survey respondents and a contributing factor for 17%. Women cited it as a contributing factor at more than three times the rate of men. Among listening session participants, 22% identified as survivors of domestic violence. Findings from the landscape scan indicated that a dedicated infrastructure consists of two programs totaling 130 beds, one in each county, and the Salem program is among the region's few walk-in options. The listening sessions documented two eligibility gaps. One survivor was excluded from a domestic violence grant because no children were in the home. One young survivor of violence in his family of origin was refused because his abuse was not intimate-partner violence. Providers described capacity denials at domestic violence shelters, and they raised the question of whether domestic violence organizations operate in connection with the broader housing response or apart from it

12.10 Justice-Involved Individuals

Criminal history is the fifth most selected employment barrier, at 21%. It was the reason for 12% of shelter turn-aways. Participants described rental screening that excluded them decades after a conviction. For people under supervision, remaining homeless can violate supervision terms while the record disqualifies them from housing. Half of providers named release from jail or

prison without housing among the reasons clients commonly share. Reentry services appear at four sheltering programs and at none as a dedicated focus. Four percent of providers reported formal agreements with criminal legal partners. Providers described people with sex offense histories, barred from most housing, shelter, and subsidy, as a population with almost no options.

12.11 People With Pets or Unable to Meet Sobriety Requirements

People with pets were identified by 42% of providers as falling through the cracks in the system. **Fifty-nine percent of providers cited pets and partners as a client access barrier,** pets were the third most common turn-away reason in the community survey, and pet ownership concentrated among unsheltered respondents, women, and people with health conditions, some of whose animals are service or support animals. Fifteen percent of programs reported an outright no-pets policy, so the barrier as experienced exceeds the stated prohibitions, with kennel space, liability, and service-animal policy likely accounting for the difference. People unable to meet sobriety requirements face the abstinence-with-testing rules that govern roughly a quarter of the region's beds. Each of these exclusions is set by program policy.

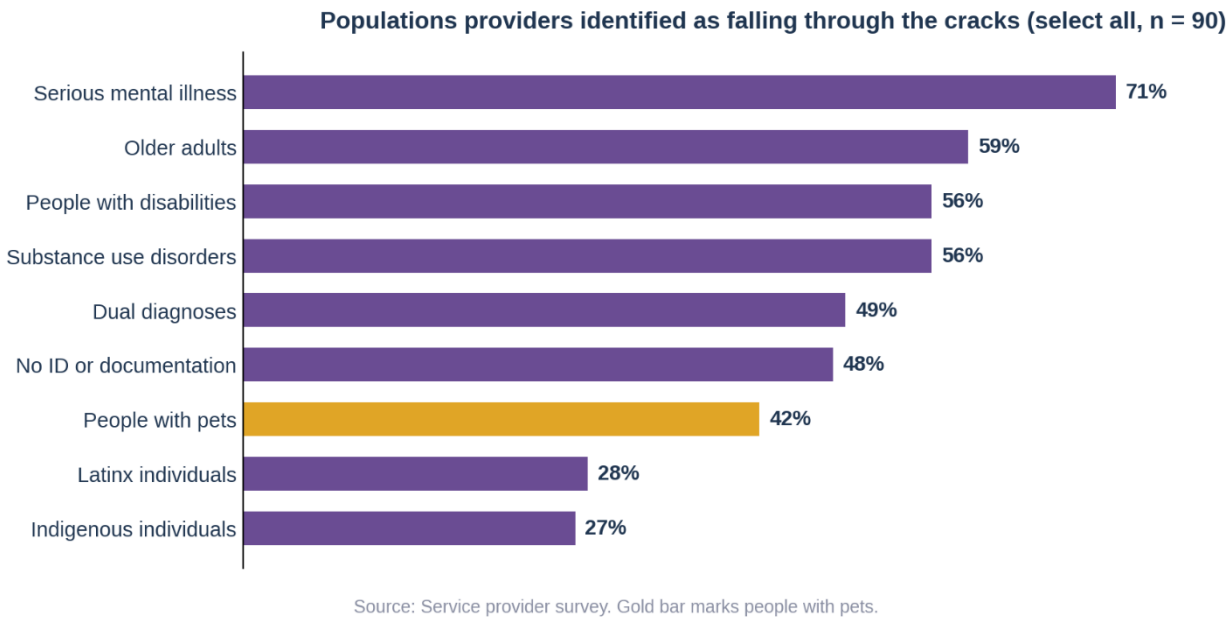


Figure 19. Populations providers identified as falling through the cracks. The gold bar marks people with pets.

Table 33. Populations providers identified as falling through the cracks (N = 90)

Population	%
People with serious mental illness	71%

Population	%
Older adults	59%
People with disabilities	56%
People with substance use disorders	56%
People with dual diagnoses	49%
People without ID or documentation	48%
People with pets	42%
Single women	27% among Coordinated entry provider participants; 53% among non-participants
Latinx individuals	28%
Indigenous individuals	27%

KEY TAKEAWAYS – POPULATIONS REQUIRING TARGETED APPROACHES

Parents of minor children reported more difficulty than other respondents on waitlists, information, and overall experience, with 15% describing their service experience as positive, and the inventory holds seven dedicated emergency family units.

Three-quarters of survey respondents reported a long-term condition. Respondents with a condition were seven times more likely to report identity-based denial.

Youth and older adults occupy the two ends of the age distribution, with 20 dedicated youth beds region-wide and older adults the population providers most often described as growing.

Rural residents described services that did not exist in their communities and the visibility of being known in a small town. Some concealed their homelessness to avoid stigma, and some declined the label itself.

13. Gaps and Unmet Needs

This section brings together what community members said they most need, what providers observe as the most common needs, and what the landscape scan documented as missing. Each source identifies gaps from a different vantage point. Community members describe what they are not getting, providers describe what they cannot offer or refer to, and the landscape scan describes what the current shelter inventory does not contain. The section moves from stated needs to capacity, geography, populations, and infrastructure, and closes with the gaps both community members and providers identified.

13.1 What People Say They Most Need and Are Not Getting

Respondents were asked to select up to three needs they are not currently getting help with. Permanent housing was the most selected, at 60%. Help paying rent or a security deposit followed at 38%. Food and income or employment support were each selected by 27%, transportation by 21%, and a safe place to sleep by 20%. The three most used services community members reported using in the last 12 months consisted of benefits assistance, food, and medical care. **The most selected unmet needs concern leaving homelessness. Rapid rehousing, a service designed to move people from homelessness into permanent housing, reached 6% of respondents in the past 12 months.**

Needs differed by housing situation. **Sheltered respondents need resources and services to help them exit homelessness. Seventy-three** percent of sheltered respondents cited permanent housing as a need. **Among unsheltered respondents, needs were spread across housing, a safe place to sleep, food, and rent help. Among respondents housed but at risk or doubled up, they expressed needing resources to help prevent them from becoming homeless such as help paying rent or a deposit** was the most selected need, ahead of permanent housing. **Among respondents currently housed, they expressed material hardship and needing support with securing food.**

Table 34. Top unmet needs among survey respondents, by housing situation

Top unmet needs	Unsheltered (n=48)	Sheltered (n=64)	At risk or doubled up (n=29)	Housed (n=18)
Permanent housing	65%	73%	41%	22%
Help paying rent or deposit	27%	44%	52%	22%
Food	31%	14%	38%	33%
Income or employment support	27%	30%	28%	17%
Transportation	13%	33%	21%	6%
Safe place to sleep	35%	16%	10%	–
Mental health services	21%	13%	14%	17%
Peer support	2%	6%	17%	6%

Note. Community member survey Q36 by recoded housing situation (n = 159; two respondents did not answer). Respondents selected up to three needs. Percentages are within each group and do not sum to 100. Group definitions follow the earlier subgroup tables. A dash indicates no respondents in that group selected the item.

13.2 What Type of Housing People Say They Need

Respondents were also asked what type of housing they most need right now. A third chose a place of their own with no program requirements attached. A quarter chose supported housing, meaning their own place with services available. Eighteen percent chose any stable housing without specifying a type. Four respondents chose transitional housing with structure and support, while 32% of the sample was living in transitional shelter or a program at the time of the survey. The housing respondents were in and the housing they said they needed differ. In the open-ended responses about what they need, employment and income appeared in 44% of answers and housing affordability in 20%. Given a list, respondents selected housing. Given a blank box, they more often described the income that would make housing attainable.

Table 35. Type of housing respondents said they most need

What type of housing do you most need right now?	n	%
A place of my own with no program requirements attached	53	33%
Supported housing: my own place with services available	41	26%
Other (write-in)	30	19%
Any stable housing, not specific about the type	29	18%
Transitional housing with structure and support	4	3%
Shared housing with others	4	3%

Note. Community member survey Q37 (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100.

13.3 What Providers Observe as the Most Common Needs

Providers were asked which needs they observe most often among clients. **Mental health services was the most selected, at 80%, followed by permanent affordable housing at 79% and rapid rehousing or rental assistance at 77%**. Transportation followed at 70%, ahead of emergency shelter beds. Culturally specific or language services (32%), childcare (29%), and services for LGBTQ+ individuals (21%) were selected least.

13.4 The Gaps Community Members and Providers Both Name First

Two gaps were named first by both groups. The first is housing that people at the region's actual income levels can occupy. Community members named it first in every format, and providers named it unprompted at more than twice the rate of any other theme. **The second is a working information layer, so that a person in crisis can find what exists, a worker can make a referral that will be impactful, and a family on a list can learn where they stand.**

KEY TAKEAWAYS – GAPS AND UNMET NEEDS

The services community members used most frequently address daily needs, and the needs they most often named as unmet concern surviving being homeless. Rapid rehousing, the service between the two, reached 6% of respondents in the past year.

Community members most often mentioned they need housing of their own, with or without services attached.

The landscape scan documented capacity gaps in transitional housing, family walk-in access, youth beds, and everything outside Salem, with 64% of programs carrying waitlists.

The infrastructure gaps affect every other gap. The system has no shared definitions, no unduplicated count, no client status channel, and no current directory.

14. Recommendations and Action Plan

14.1 The Plan at a Glance

This section answers the assessment's final question, what high-impact, actionable steps can improve services and outcomes in Marion and Polk Counties. It brings together what the assessment found and what community partners added during a sensemaking session in late September 2026. A sensemaking session is a facilitated working meeting where community partners review the findings together, test them against what they see in their own work and lives, and decide what the findings mean for action. During the sensemaking session, participants worked in small groups to review the draft recommendations, name additional needs and root causes, and propose next steps and the organizations that could support the work. That discussion, together with the evidence in this report, shaped the recommendations and action plan in this section.

The plan is organized into 11 priority areas under four themes. The first theme covers keeping people housed and meeting basic needs. The second covers how the system works together. The third covers housing and care for people whom current programs do not fit. The fourth covers place, culture, and public understanding.

Each priority area opens with a goal, a short statement of what the work aims to change. It then describes what the findings show, drawing on the assessment and the sensemaking session. From there, the plan lays out the strategies for that area. Sixty-eight strategies appear across the plan, each numbered by its priority area. An action plan follows each set of strategies. It names the first steps, who could lead them, which partners could join, and when the work could begin. Each priority area closes with milestones that show progress and the groups still to bring into the work.

During the sensemaking session, participants named their own organizations, and others, that could lead or support work in a priority area. **No organization listed in this document has committed to a role. These names are suggestions from session participants and the research team**, for MWVCAA, its partners and the community to use in future conversations.

The table below gives each priority area, its goal, and its strategies. The pages that follow describe each one in full.

Table 36. Priority areas, goals, and strategies at a glance, by theme

Priority	Priority area and goal	Strategies
Theme A. Keeping People Housed and Meeting Basic Needs		
1	**Prevention and Housing Stability** Households at risk of losing housing get help early enough to stay housed, and they stay housed after the help ends.	• Create a flexible regional housing and diversion fund with minimal program conditions. • Treat households at risk of losing housing as a distinct population with a distinct intervention. • Address the barriers that turn a crisis into housing loss. • Fund renter education. • Measure housing stability after assistance ends.
2	**Basic Needs, Identification, and Staying Reachable** People without housing can meet daily needs, keep their documents, and be reached when help becomes available.	• Fund basic dignity infrastructure in every community where people sleep outside. • Extend hygiene access beyond current hours and locations. • Remove the identification barrier. • Fix the contact problem. • Share what exists where people first make contact.
Theme B. How the System Works Together		
3	**Coordination, Coordinated Entry, and Shared Information** People move through one coordinated system, and providers share current information about what is available.	• Repair Coordinated Entry. • Report Coordinated Entry performance alongside housing inventory. • Build a shared, current capacity and eligibility directory, paired with a staffed phone and in-person channel. • Connect outreach, peer, and day center staff to system information. • Convene a quarterly regional resource summit with frontline staff present. • Develop a coordination framework that scales with conditions such as severe weather. • Define what collaborative funding looks like.

Priority	Priority area and goal	Strategies
4	**Program Rules and Access to Housing** Program and screening rules let in the people programs are meant to serve.	• Review program rules separately from program capacity, and publish the results. • Address the pets and partners barrier. • Extend ban-the-box protections to rental applications, and exclude credit history accrued during documented homelessness from screening. • Connect domestic violence organizations to the broader housing response and widen eligibility. • Design for the populations existing programs do not fit. • Bring landlords and property managers into the work. • Pair housing access with longer-term support.
5	**Workforce, Peers, and Data** The workforce is staffed and supported to do the work, and the region learns from shared, unduplicated data.	• Fund staffing rather than programs where possible. • Invest in peer support specialists. • Close the counting gap. • Share data across organizations with consent. • Fund shared equity outcome analysis and return the results to frontline staff. • Collect client feedback routinely, and record the reason for every refusal. • Publish annual reports by agency and program.
Theme C. Housing and Care for People Whom Current Programs Do Not Fit		
6	**Housing Supply and Pathways from Shelter** People in shelter can move into housing they can afford, and people keep the affordable housing they have.	• Expand housing supply priced to the incomes people have. • Add small-unit housing. • Preserve naturally affordable housing. • Create flexible funding for one-time repairs. • Protect and expand what providers identified as working. • Fund transitional and supportive housing steadily. • Connect shelter to coordinated entry and housing referral.
7	**Behavioral Health, Health Care, and Higher-Needs Care** People with behavioral health, medical, and daily-living needs have care and placements that fit those needs.	• Build behavioral health support across the age span. • Add behavioral health stabilization and emergency beds. • Create specialized care beds and medical respite. • Build institutional discharge partnerships. • Close the gap between health coverage and care. • Sustain urgent medical and mental health response. • Provide housing with ongoing support for people with serious mental illness.

Priority	Priority area and goal	Strategies
8	**Youth and Families** Young people and families have shelter and support that fit them, close to their own communities.	• Rebuild transitional and family walk-in capacity. • Establish at least one 24-hour access point for families in each county. • Plan youth services and family services as separate systems. • Keep young people and families in their communities. • Configure family shelter for all family types. • Support young adults leaving youth systems. • Expand services for survivors in families. • Pair early intervention with longer-term follow-up.
Theme D. Place, Culture, and Public Understanding		
9	**Rural Communities** Rural residents can reach shelter and services in or near their own communities.	• Fund rural service delivery as rural service delivery. • Collect town-by-town data and a service inventory. • Identify communities that can host full-service shelter. • Expand rural shelter and housing options. • Increase rural Marion County representation. • Build rural community buy-in.
10	**Culturally Specific Services and Tribal Engagement** Incorporate culturally responsive practices in all aspects of service provision. Establish authentic partnerships, working alongside Tribal nations and culturally specific organizations.	• Establish a Tribal engagement pathway and plan, training staff on Tribal history, practices and respectful engagement and building on existing relationships. • Fund language access and cultural responsiveness as separate investments. • Work alongside culturally specific organizations, honoring their expertise and devoting resources reflective of authentic partnership. • Create culturally safe spaces and outreach. • Work collaboratively to identify service gaps and design effective solutions.
11	**Public Understanding, Community Buy-In, and Policy Advocacy** Residents, elected officials, and funders share an accurate picture of homelessness in the region and act on it.	• Share the findings widely. • Offer ongoing data education for elected officials at every level. • Develop public communications that correct common myths. • Coordinate advocacy at the city, state, and federal levels.

14.2 The Detailed Recommendations and Strategic Plan

This part of the plan sets out each priority in detail. For each one, it gives the goal, what the findings show, and the strategies. The strategies bring together the approaches participants identified at the sensemaking session and the findings of the full assessment. An action plan follows, with first steps, possible leads and partners, and timeframes. Milestones and the voices to bring into the work close each priority.

Theme A. Keeping People Housed and Meeting Basic Needs

The two priorities under this theme address what happens before a household loses housing and what people need each day while they are without it.

Priority 1. Prevention and Housing Stability

Goal. Households at risk of losing housing get help early enough to stay housed, and they stay housed after the help ends.

What the Findings Show

Sixty-nine percent of the sample received no prevention support before losing housing. Of the 50 respondents who received support, 60% reported that it helped for a while and 40% that it was not enough to prevent homelessness. Among the 29 respondents housed but at risk or doubled up, rent and deposit assistance was the most cited need. One-time help with arrears and a month or two of rent addresses a crisis. It does not close a gap between income and rent that continues after the payment.

Flexible funding was the support providers selected most often for expanding diversion, at 57%. Thirty-six percent of providers already practice diversion informally, without funding or measurement.

Participants at the sensemaking session raised prevention in several small groups, and one group formed to work on it alone. They named deposits, emergency rent help, renter education, and budgeting support. They described barriers that turn a crisis into housing loss, including eviction history, rental history, no or low credit, and damage caused by abuse in the home. A former navigation center staff member described people returning to homelessness after rental assistance ended at month 12.

Strategies

1.1 Create a flexible regional housing and diversion fund with minimal program conditions. Place it at the first point of contact, inside the services people already use. Cover deposits, emergency rent, arrears, and one-time costs that would otherwise lead to housing loss. Fund and measure the diversion work providers already do informally.

1.2 Treat households at risk of losing housing as a distinct population with a distinct intervention. Plan, fund, and track prevention for this group separately from services for people already homeless. For households with an ongoing gap between income and rent, pair one-time help with a pathway into longer-term rental assistance or rapid rehousing.

1.3 Address the barriers that turn a crisis into housing loss. Focus on eviction history, rental history, no or low credit, and damage caused by abuse in the home.

1.4 Fund renter education. Include Rent Well and utilize paid instructors.

1.5 Measure housing stability after assistance ends. Track whether households stay housed after rental assistance ends, not only whether they were placed.

Action Plan

Table 37. Action plan for Priority 1, prevention and housing stability

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Map current prevention resources in both counties, with funders, eligibility, and points of access.	MWVCAA	Prevention providers. Housing authorities.	First half of 2027
Convene prevention partners to discuss prevention options and how organizations can collaborate.	Northwest Human Services and MWVCAA	Marion and Polk Counties. City of Salem.	During 2027
Adopt a working definition of households at risk and shared prevention measures, including housing status after assistance ends.	Mid-Willamette Valley Homeless Alliance	Prevention providers. Agency data administrators.	During 2027
Identify funding sources and written rules for the flexible fund.	MWVCAA	City of Salem. Marion and Polk Counties. Oregon Housing and Community Services.	During 2027
Launch or expand renter education classes.	Renter education providers	Housing authorities. Landlords and property managers.	During 2027

Milestones

- A shared definition of households at risk is adopted.
- The flexible fund operates with written, minimal conditions.
- Prevention and diversion results are reported, including housing status after assistance ends.

Voices to bring in. People with lived experience of homelessness. School district McKinney-Vento liaisons. Northwest Senior and Disability Services. Domestic violence service providers.

Priority 2. Basic Needs, Identification, and Staying Reachable

Goal. People without housing can meet daily needs, keep their documents, and be reached when help becomes available.

What the Findings Show

Restrooms, showers, laundry, water, trash service, and secure storage were the most frequently named needs across all seven lived-experience sessions. Community data shared at the

sensemaking session showed no showers available after 10 p.m. One participant described hygiene, waste disposal, and bathrooms as basic government infrastructure that providers keep filling.

Young adults named the cost of replacing their license or state identification as the barrier standing between them and work. Participants described documents lost through sweeps and theft, and a young person who had used up time-limited ID vouchers.

Eighteen percent of respondents have no working phone, and 40% of unsheltered respondents have limited or no internet. Participants said people learn about hygiene and ID resources too late or not at all.

> *"Better sheltering. Some shelters are very strict with rules, some that are very rude, and some that just don't really understand what people go through. We need and deserve a safe space."*
>
> Community Member Listening Session, Salem

Strategies

2.1 Fund basic dignity infrastructure in every community where people sleep outside. Provide restrooms, showers, laundry, potable water, trash service, and secure storage. Start where need is concentrated, such as Marion Square.

2.2 Extend hygiene access beyond current hours and locations. Add mobile showers and laundry in Salem and in rural communities, with staff to maintain them.

2.3 Remove the identification barrier. Subsidize replacement documents, remove the fee-waiver frequency cap, and pair replacement with secure storage. Cover documents lost in sweeps and theft.

2.4 Fix the contact problem. Replace mail-only notification with text, email, and agency-side alerts, and extend response windows for applicants without stable addresses. Expand free phone programs, and extend the ARCHES day center's contact approach to other partner agencies.

2.5 Share what exists where people first make contact. Use outreach teams, day centers, and drop-in sites to share hygiene, identification, and contact resources.

Action Plan

Table 38. Action plan for Priority 2, basic needs, identification, and staying reachable

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold conversations among shelters and providers about funding needs and partnerships for hygiene services.	The ARCHES day center (MWVCAA)	Shelters. Day centers. Mobile shower and laundry providers.	By January 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Inventory hygiene, storage, identification, and phone resources, with hours and locations.	MWVCAA	Day centers. Street outreach teams.	First half of 2027
Identify sites and funding for after-hours and mobile hygiene services, including in rural communities.	City and county governments	Shelters and day centers. Mobile hygiene providers.	During 2027
Work with agencies that issue identification documents on fee waivers and replacement frequency.	MWVCAA	State and county agencies that issue documents.	During 2027
Adopt text and email notification across programs, with longer response windows.	Mid-Willamette Valley Homeless Alliance	Program operators.	During 2027
Collect feedback from people who use these services to track whether access grows.	Shelters and day centers	People with lived experience of homelessness.	Multi-year

Milestones

- Hygiene services operate after day center hours in Salem and in rural communities.
- Replacement documents are available without a frequency cap.
- Programs notify applicants by text or email as well as by mail.

Voices to bring in. People with lived experience of homelessness, including people disconnected from services. Police, law enforcement, and code enforcement. Neighborhood associations and the business community.

Theme B. How the System Works Together

The three priorities under this theme address how providers coordinate, which rules decide who gets in, and the staff and data the system runs on.

Priority 3. Coordination, Coordinated Entry, and Shared Information

Goal. People move through one coordinated system, and providers share current information about what is available.

What the Findings Show

None of 90 provider respondents selected the option that Coordinated Entry is working well, and the gaps they named are specific. Sixty-eight percent of participating providers identified insufficient housing and programs to refer to as the biggest gap. Seventy-eight percent reported that clients do not know what exists, and the region has no shared wait-time definition. Inadequate communication structures were the most named coordination barrier, at 51%. The staff with the most direct contact with unsheltered people reported the least connection to system infrastructure.

Participants at the sensemaking session named fragmented funding and accountability, competition for limited resources, organizational silos, and systems designed around programs as root causes. They gave the example of a shelter that lists 25 beds when 15 are available.

Strategies

3.1 Repair Coordinated Entry. Pilot a documented mechanism for worker observation to inform prioritization without overriding client self-determination. Create a status channel clients can use. Audit assessment fidelity across access points and retrain where scores diverge from expected distributions. Organize it as one front door across providers, toward a “no wrong door” approach, and review how it works for young people.

3.2 Report Coordinated Entry performance alongside housing inventory. Publish coordinated entry results, such as how many people are assessed, how long they wait, and how many move into housing, next to the number of housing units and program openings available, so readers can see when delays come from limited housing rather than from the referral process itself.

3.3 Build a shared, current capacity and eligibility directory, paired with a staffed phone and in-person channel. Track available beds, outreach counts, and service disruptions as they change, and set a shared wait-time definition.

3.4 Connect outreach, peer, and day center staff to system information. Include them in CoC communication, referral status updates, and the capacity directory. Set regular communication among street outreach, crisis response, and shelter providers, with communication hours extended to at least 9 p.m.

3.5 Convene a quarterly regional resource summit with frontline staff present. Use it to build communication channels, community among providers, and warm handoffs.

3.6 Develop a coordination framework that scales with conditions such as severe weather. Use emergency management and incident command principles so coordination expands during events and contracts afterward.

3.7 Define what collaborative funding looks like. Share grant information and pursue joint applications among organizations doing complementary work.

Action Plan

Table 39. Action plan for Priority 3, coordination, coordinated entry, and shared information

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold a roundtable of agency leaders on shared values, collective decision-making, and collaborative funding.	Mid-Willamette Valley Homeless Alliance and MWVCAA	Agency executive directors. Advocates and frontline staff.	By January 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Schedule and hold the first quarterly regional resource summit.	MWVCAA	Providers and frontline staff.	First half of 2027
Scope the capacity and eligibility directory, starting with shelter beds.	Mid-Willamette Valley Homeless Alliance	211info. Shelter providers.	First half of 2027
Draft a scalable coordination framework with defined roles and decision-making authority.	City and county emergency management	MWVCAA. Northwest Human Services. Mid-Willamette Valley Homeless Alliance. 211info.	During 2027
Begin the coordinated entry fidelity audit and pilot a client status channel.	Mid-Willamette Valley Homeless Alliance	Coordinated entry access points. Youth-serving organizations.	During 2027
Draft interagency coordination protocols and memoranda of understanding.	Mid-Willamette Valley Homeless Alliance	Shelter, housing, outreach, and crisis response providers.	During 2027

Milestones

- The regional resource summit meets each quarter.
- The capacity directory is live, with a shared wait-time definition.
- Coordinated entry performance is reported alongside housing inventory.
- The fidelity audit is complete and retraining is under way where needed.

Voices to bring in. Youth-serving organizations. People with lived experience of homelessness. Criminal justice and law enforcement partners.

Priority 4. Program Rules and Access to Housing

Goal. Program and screening rules let in the people programs are meant to serve.

What the Findings Show

Sixty-three percent of programs described themselves as low barrier, and 52% of those reported at least one active requirement. Pets were named by 42% of providers as a population falling through the cracks and were the third most common turn-away reason. A criminal record was the reason for 12% of turn-aways and an employment barrier for 21% of respondents.

The region holds no dedicated programming for several groups. These include single adults without children, single fathers, two-parent families, fixed-income adults without a substance use diagnosis, people with sex offense histories, Deaf and disabled residents, and LGBTQ+ residents.

Participants at the sensemaking session described screening on credit, rental, and criminal history, and credit damage after domestic violence or a layoff that delays rapid rehousing. They named the costs property managers face for tenants with higher needs. They asked to widen domestic violence eligibility and to serve couples and two-adult households affected by secondary victimization.

Strategies

4.1 Review program rules separately from program capacity, and publish the results. Convene the people who design and administer program rules, starting with mental health programs, and show how specific rules restrict access.

4.2 Address the pets and partners barrier. Fund kenneling, veterinary basics, and facility adaptation.

4.3 Extend ban-the-box protections to rental applications, and exclude credit history accrued during documented homelessness from screening. Address credit damage that follows domestic violence or a layoff.

4.4 Connect domestic violence organizations to the broader housing response and widen eligibility. Establish a confidential referral and follow-up pathway between domestic violence organizations and Coordinated Entry that does not require survivors' information to enter HMIS. Widen domestic violence eligibility to include family-of-origin violence, survivors without children, and couples and two-adult households affected by secondary victimization.

4.5 Design for the populations existing programs do not fit. Start with the groups for whom the region holds no dedicated programming, listed above. Priority 8 addresses family shelter configuration.

4.6 Bring landlords and property managers into the work. Offer incentives tied to the costs of serving tenants with higher needs. Enforce fair housing and ADA protections, including where violations are systemic.

4.7 Pair housing access with longer-term support. Provide deeper, longer-term transitional support and tenant education alongside financial help.

Action Plan

Table 40. Action plan for Priority 4, program rules and access to housing

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Host a conversation on housing access barriers.	Community partners	Landlords and property managers. People with lived experience. Fair housing organizations.	Within 90 days (by December 29, 2026)

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Review program rules across shelter and housing programs and publish the results.	Mid-Willamette Valley Homeless Alliance	Program operators. Funders that set program rules.	During 2027
Design the confidential domestic violence referral pathway into Coordinated Entry.	Domestic violence service providers and Mid-Willamette Valley Homeless Alliance	Coordinated entry access points.	During 2027
Develop landlord incentive options.	Housing authorities	Property managers. Oregon Housing and Community Services.	During 2027
Pursue ban-the-box and credit screening changes for rental applications.	Advocates	City councils. Legislators. Fair housing organizations.	Multi-year

Milestones

- The program rules review is published.
- The confidential domestic violence referral pathway is operating.
- A landlord incentive is in place.

Voices to bring in. Legislators. Criminal justice partners. Recovery services.

Priority 5. Workforce, Peers, and Data

Goal. The workforce is staffed and supported to do the work, and the region learns from shared, unduplicated data.

What the Findings Show

Half of providers named funding that does not cover staffing, rising to 77% among leadership. Of 65 community members who had received peer support, 50 found it very helpful, and 45 more wanted it but had not received it. Three-quarters of organizations already employ peer specialists.

Race is recorded at intake at six times the rate it is analyzed against outcomes, and every organization that analyzes outcomes by race already collects the demographic data. Client feedback is collected by 23% of providers. Among respondents who had been turned away, 23% were told they did not qualify with no reason given. Thirteen sheltering programs operate outside HMIS, so the region has no unduplicated count of system reach.

Participants at the sensemaking session named rural providers among the shelters outside HMIS. They asked for standardized case management documentation, universal releases of information, annual reports by agency and program, and professional training and living wages so staff stay longer.

Strategies

5.1 Fund staffing rather than programs where possible. Build staffing adequacy, supervision, coverage depth, and reflective practice into grant budgets rather than treating them as indirect cost. Design in wellness support and coverage depth for organizations that hire from lived experience, including paid self-care time within scheduled hours, professional training, and living wages.

5.2 Invest in peer support specialists. Increase positions, fund warm handoffs into housing, and add peer and community health worker capacity at high-traffic sites where present staff are not authorized to help with paperwork.

5.3 Close the counting gap. Bring the 13 sheltering programs outside HMIS, including rural providers, into a shared reporting approach designed to fit peer-run and small organizations. Standardize cost-per-bed and waitlist definitions. Produce the region's first unduplicated count of system reach. Pair volume measures with quality measures in grantor expectations.

5.4 Share data across organizations with consent. Adopt a universal release of information and standardize case management documentation.

5.5 Fund shared equity outcome analysis and return the results to frontline staff. Use a regional data coordinator or pooled evaluation support to run disaggregated analysis on data providers already hold, including race and other factors in rapid rehousing follow-up results.

5.6 Collect client feedback routinely, and record the reason for every refusal. Give each person the reason and a next step, so both denials and their causes are visible.

5.7 Publish annual reports by agency and program. Use them to set strategy and to show staff the impact of their work.

Action Plan

Table 41. Action plan for Priority 5, workforce, peers, and data

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Identify the shelters outside HMIS and what each would need to participate.	Mid-Willamette Valley Homeless Alliance	Rural and peer-run providers.	First half of 2027
Build the capacity of governing bodies to create shared data protocols, including a universal release of information.	Mid-Willamette Valley Homeless Alliance board and committees	Agency data administrators.	During 2027
Hold in-person meetings for data administrators and line staff to share practices that do and do not work.	Agency data administrators	Line staff. Peer support specialists.	During 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Agree on shared outcome measures, including breakdowns by race and other factors and recorded refusal reasons.	Mid-Willamette Valley Homeless Alliance	Providers. Culturally specific organizations.	During 2027
Revise grant budget guidance to cover staffing, supervision, wellness, and peer positions.	Funders	Providers.	Multi-year

Milestones

- The region produces its first unduplicated count of system reach.
- A universal release of information is in use.
- Equity outcome results are returned to frontline staff.
- Refusals are recorded with their reasons.

Voices to bring in. People with lived experience of homelessness. Culturally specific organizations.

Theme C. Housing and Care for People Whom Current Programs Do Not Fit

The three priorities under this theme address the supply of housing people can afford, the care some people need to be housed safely, and the specific needs of young people and families.

Priority 6. Housing Supply and Pathways from Shelter

Goal. People in shelter can move into housing they can afford, and people keep the affordable housing they have.

What the Findings Show

Providers recommended expanding supply at 43%, more than twice any other theme. Sixty-four percent of community members who reported an income amount earn less than $500 per month. Providers named non-congregate shelter, street outreach, direct agency-to-agency handoffs, and the culturally specific multilingual navigation model as practices that work well.

Participants at the sensemaking session described too little housing of any type for people in shelter who are ready to move, and shelter turnover as stalled. They named people living on about $994 a month in Social Security, people slightly over program income limits, working people, and older adults as households the current supply misses. They described the loss or rising cost of naturally affordable housing, including mobile home parks, and housing lost to small barriers such as one-time repairs.

Strategies

6.1 Expand housing supply priced to the incomes people have. Include people on fixed incomes, working households, and people just above program income limits.

6.2 Add small-unit housing. Change code and zoning to allow single-room occupancy units, studios, and building up rather than out.

6.3 Preserve naturally affordable housing. Protect mobile home and manufactured housing communities and their space rents, especially for people 55 and older. Expand RV and park capacity with utility hookups and without model-year restrictions.

6.4 Create flexible funding for one-time repairs. Cover repairs such as roofs and weatherization that keep people in the housing they have.

6.5 Protect and expand what providers identified as working. Sustain non-congregate shelter, street outreach, direct agency-to-agency handoffs, and the culturally specific multilingual navigation model. Keep the model in which MWVCAA handles administration and partners provide case management, and ease movement from rapid rehousing to long-term rental assistance.

6.6 Fund transitional and supportive housing steadily. Use Medicaid-funded permanent supportive housing where possible, and review permanent supportive housing outcomes to build shared practice.

6.7 Connect shelter to coordinated entry and housing referral. Operate regional shelter 24 hours a day with a day option, so shelter works as a route into housing.

Action Plan

Table 42. Action plan for Priority 6, housing supply and pathways from shelter

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Compile local code and zoning provisions that limit small units, single-room occupancy, RV parks, and density.	City and county planning offices	Affordable housing developers. MWVCAA.	First half of 2027
Identify mobile home and manufactured housing communities at risk of closure or rising space rents.	MWVCAA	Oregon Housing and Community Services. Community residents.	During 2027
Scope a one-time repair fund with existing home repair and weatherization programs.	MWVCAA	Home repair and weatherization programs.	During 2027
Review rapid rehousing and permanent supportive housing outcomes, including returns to homelessness.	Mid-Willamette Valley Homeless Alliance	Housing providers.	During 2027
Pursue new deeply affordable and small-unit development.	Housing authorities and affordable housing developers	Oregon Housing and Community Services. City and county governments.	Multi-year

Milestones

- Code and zoning changes that allow small units are adopted.
- The one-time repair fund is operating.
- A review of permanent supportive housing outcomes is published.

Voices to bring in. Legislators. Neighborhood associations and the business community. Residents of manufactured home communities.

Priority 7. Behavioral Health, Health Care, and Higher-Needs Care

Goal. People with behavioral health, medical, and daily-living needs have care and placements that fit those needs.

What the Findings Show

Eighty-six percent of respondents have health insurance, and 43% used an emergency room in the past year because they could not get care elsewhere. Respondents described appointment availability, transportation, provider willingness, and the difficulty of attending scheduled care while homeless as the barriers. Half of providers named jail or prison release among the circumstances clients commonly share, and 4% hold a formal criminal legal agreement.

Participants at the sensemaking session described people whose needs exceed what shelters can serve. Low-barrier shelters still exit people when behavior escalates. People discharged from hospitals who cannot manage activities of daily living fall outside what shelters can serve. Seventeen of the needs participants recorded during the session concerned behavioral health, health care, and higher-needs care, from stabilization beds and medical respite to Oregon Health Plan enrollment and longer-term support for people with serious mental illness.

Strategies

7.1 Build behavioral health support across the age span. Serve children in family shelters, parents, adults, and older adults.

7.2 Add behavioral health stabilization and emergency beds. Serve people whose needs exceed what shelters can manage.

7.3 Create specialized care beds and medical respite. Fill the space between regular shelter and permanent supportive housing or assisted living, for people who need help with activities of daily living and for medically fragile older adults.

7.4 Build institutional discharge partnerships. Pursue data sharing and warm-handoff agreements with jails, hospitals, treatment facilities, and child welfare, so people are not discharged to shelters that cannot serve them.

7.5 Close the gap between health coverage and care. Fund delivery models that fit the population the coverage already pays for. These include street medicine and mobile clinics, co-located primary and behavioral health care at day centers and shelters, and a hospital partnership pairing the discharge agreements with emergency-room-based housing navigation. Help people enroll in and keep Oregon Health Plan coverage.

7.6 Sustain urgent medical and mental health response. Fund REACH for the long term and expand it to seven days a week and to Polk County.

7.7 Provide housing with ongoing support for people with serious mental illness. Include people with severe and persistent mental illness, and offer ongoing substance use support so people can stabilize.

Action Plan

Table 43. Action plan for Priority 7, behavioral health, health care, and higher-needs care

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Convene behavioral health, hospital, and shelter partners to map where people go after shelter exits and hospital discharges, and where those paths break.	Marion County and Polk County behavioral health	Hospital systems. Shelter providers. Northwest Senior and Disability Services. Developmental disability services.	First half of 2027
Estimate the need for stabilization, specialized care, and medical respite beds.	Marion County and Polk County behavioral health	Hospital systems. Oregon Health Authority.	During 2027
Draft discharge and warm-handoff agreements.	Hospital systems and Mid-Willamette Valley Homeless Alliance	Jails. Treatment facilities. Child welfare.	During 2027
Identify funding for REACH expansion and long-term operations.	REACH and its funders	Polk County. City and county governments.	During 2027
Offer Oregon Health Plan enrollment support at shelters and day centers.	Oregon Health Authority and the regional coordinated care organization	Shelters. Day centers.	During 2027

Milestones

- Discharge and warm-handoff agreements are signed with hospitals and other institutions.
- REACH operates seven days a week and serves Polk County.
- Enrollment support is available at shelters and day centers.

Voices to bring in. Health care, behavioral health, and recovery services. Families caring for relatives with chronic mental illness.

Priority 8. Youth and Families

Goal. Young people and families have shelter and support that fit them, close to their own communities.

What the Findings Show

Transitional capacity runs through 15 small programs, family walk-in capacity stood at five open units, and dedicated youth capacity is 20 beds.

Participants at the sensemaking session noted that the largest family shelter is in downtown Salem, which pulls children out of their school communities. They described family shelter that has no arrangement for teenage boys ages 14 to 16 or for fathers, and families whose children have high behavioral health or developmental needs. Young adults aging out of youth systems lack rental history and face background check barriers. One participant contrasted the system's focused work on veterans with no comparable focus on youth.

Strategies

8.1 Rebuild transitional and family walk-in capacity. Expand long-term shelter for families and long-term housing for youth in child welfare.

8.2 Establish at least one 24-hour access point for families in each county. Design it as a one-stop point of entry.

8.3 Plan youth services and family services as separate systems. Give each its own goals, outcomes, and infrastructure.

8.4 Keep young people and families in their communities. Add rural youth access points and a small emergency youth shelter in rural Marion County. Develop a rural family shelter model funded jointly by the county, schools, cities, and organizations.

8.5 Configure family shelter for all family types. Include teenage boys, fathers, two-parent families, and families whose children have high behavioral health or developmental needs.

8.6 Support young adults leaving youth systems. Expand independent living, add a day center for ages 18 to 24, and address rental history and background check barriers.

8.7 Expand services for survivors in families. Provide legal representation, childcare, and domestic violence services for youth abused by family members.

8.8 Pair early intervention with longer-term follow-up. Keep to the wraparound model.

Action Plan

Table 44. Action plan for Priority 8, youth and families

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold a stakeholder meeting on youth and family services, with data and education, and ask regional organizations to prioritize youth services.	MWVCAA and the Mid-Willamette Valley Homeless Alliance	Youth-serving organizations. Oregon Department of Human Services. McKinney-Vento staff.	By January 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Raise awareness of existing family shelter.	Family shelter providers	Schools. Street outreach teams.	By January 2027
Build and maintain a current catalog of youth and family resources.	MWVCAA	Youth-serving organizations. 211info.	First half of 2027
Gather rural youth and family data and size rural shelter options.	MWVCAA	School districts and McKinney-Vento liaisons.	During 2027
Review how coordinated entry works for young people, as part of the coordinated entry repair in Priority 3.	Mid-Willamette Valley Homeless Alliance	Youth-serving organizations. Young people with lived experience.	During 2027

Milestones

- A 24-hour family access point operates in each county.
- Youth and family services have separate, adopted goals and outcomes.
- A rural youth and family shelter plan is funded.

Voices to bring in. Child welfare offices serving Marion County. Family and youth representation. Young people with lived experience of homelessness.

Theme D. Place, Culture, and Public Understanding

The three priorities under this theme address rural communities, culturally specific and Tribal engagement, and the public and political support the other priorities depend on.

Priority 9. Rural Communities

Goal. Rural residents can reach shelter and services in or near their own communities.

What the Findings Show

Participants at the sensemaking session described rural Marion County as underrepresented at all levels. They described an unwillingness to provide shelter across rural Marion County apart from Woodburn, and named the Santiam Canyon and south county. They said stigma keeps some people from identifying as homeless, such as people living in RVs without hookups, and that rural providers are often outside HMIS.

Groups named limited housing of all types, lack of services and shelter in most communities, transportation and geography, and intergenerational poverty as root causes. They named existing rural resources, including municipalities, schools, faith communities, hospitals, Tribal communities, emergency services, food banks, and day centers in Stayton and Woodburn.

Strategies

9.1 Fund rural service delivery as rural service delivery. Provide scheduled and publicized mobile services, local day space, laundry access, transportation, and warming criteria that open on the first cold night. Add a central basic needs hub in rural Marion County based on the Silverton model, after-hours services, mobile medical care, and transportation to medical care for older adults.

9.2 Collect town-by-town data and a service inventory. Lead it locally, with support, so each small community's needs are visible. Include rural providers outside HMIS.

9.3 Identify communities that can host full-service shelter. Plan for 24-hour access, basic needs, and supportive services, building on practices already working in rural communities.

9.4 Expand rural shelter and housing options. Add rural domestic violence shelter, rural permanent supportive housing, and rural prevention and longer-term rent support.

9.5 Increase rural Marion County representation. Include rural communities in planning and decision-making bodies.

9.6 Build rural community buy-in. Present the data to residents, city councilors, and county commissioners through town halls and stakeholder meetings.

Action Plan

Table 45. Action plan for Priority 9, rural communities

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold a rural stakeholder meeting that produces an action plan.	MWVCAA	Center for Hope and Safety. Polk County. Northwest Human Services. City governments.	By January 1, 2027
Present findings at rural town halls and to city councils and county commissions.	MWVCAA regional coordinator	Rural providers. City councilors and county commissioners.	First half of 2027
Begin locally led, town-by-town data collection and a service inventory.	MWVCAA regional coordinator	Rural providers. Cities. Schools.	During 2027
Design and fund local services in communities ready to host them.	Rural providers and city governments	Hospitals, MWVCAA, and the Mid-Willamette Valley Homeless Alliance as funders.	Multi-year

Milestones

- A town-by-town needs and service inventory is complete.
- Warming criteria open on the first cold night across rural communities.

- Rural Marion County has seats on regional planning bodies.

Voices to bring in. Rural Marion County communities. Tribal communities. The business community. People with lived experience of homelessness in rural areas.

Priority 10. Culturally Specific Services and Tribal Engagement

Goal. Incorporate culturally responsive practices in all aspects of service provision. Establish authentic partnerships, working alongside Tribal nations and culturally specific organizations.

What the Findings Show

Sixty-two percent of the workforce is unaware that Tribal nations are present in the region. Culturally specific providers already reach households other programs do not.

Participants at the sensemaking session asked for culturally safe spaces and services that meet cultures where they are rather than expecting people to reach out. They named Tribal representation from The Confederated Tribes of Grand Ronde and The Confederated Tribes of Siletz Indians, and culturally specific organizations, as missing from the session.

Strategies

10.1 Establish a Tribal engagement pathway and plan, training staff on Tribal history, practices, and respectful engagement and building on existing relationships. Approach Tribal partners with respect and awareness of their sovereignty. Develop the pathway with Tribal governments, through each nation's preferred channels.

10.2 Fund language access and cultural responsiveness as separate investments. Fund contracted interpretation to replace family-member interpretation, particularly in domestic violence and behavioral health settings. Invest in the culturally specific providers already reaching households other programs do not. Treat belonging as a distinct, measured outcome.

10.3 Work alongside culturally specific organizations, honoring their expertise and devoting resources reflective of authentic partnership. Create and support authentic collaborations with culturally specific organizations, ensuring timely notification of and open access to funding opportunities and trainings.

10.4 Create culturally safe spaces and outreach. Meet communities where they are rather than waiting for people to reach out.

10.5 Work collaboratively to identify service gaps and design effective solutions. Learn which communities the current system does not reach and why. Employ local community expertise, culturally responsive and best practices to design effective solutions.

Action Plan

Table 46. Action plan for Priority 10, culturally specific services and Tribal engagement

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Develop and implement training on Tribal history, practices, and respectful engagement for staff throughout the provider system.	Mid-Willamette Valley Homeless Alliance	Service providers throughout Marion and Polk counties; Tribal partners, as each nation chooses.	During 2027
Review language access and culturally responsive service availability across shelters and coordinated entry.	Mid-Willamette Valley Homeless Alliance	Shelter providers throughout Marion and Polk counties; Culturally specific organizations and providers.	During 2027
Culturally specific organizations identify the agencies and systems they want to meet with.	Culturally specific organizations	MWVCAA; service providers throughout Marion and Polk Counties	During 2027
Invite The Confederated Tribes of Grand Ronde and The Confederated Tribes of Siletz Indians to shape the Tribal engagement pathway.	MWVCAA	Mid-Willamette Valley Homeless Alliance.	During 2027

Milestones

- Training on Tribal history, practices, and respectful engagement has been selected and implemented at provider organizations throughout the region.
- Tribal engagement pathway and plan are developed.
- Contracted interpretation is in place throughout the system, especially in domestic violence and behavioral health settings.
- Belonging is measured as an outcome.

Voices to bring in. The Confederated Tribes of Grand Ronde; The Confederated Tribes of Siletz Indians; Chemawa Indian School; Culturally specific organizations.

Priority 11. Public Understanding, Community Buy-In, and Policy Advocacy

Goal. Residents, elected officials, and funders share an accurate picture of homelessness in the region and act on it.

What the Findings Show

Participants at the sensemaking session called for town halls and stakeholder meetings that present the data to residents, councilors, and commissioners, and noted the rural political climate. They called for targeted advocacy at the city, state, and federal levels, communications

that correct myths and humanize people, and ongoing data education for elected officials. A group working on health care named state policies that are barriers to actual needs.

The session closed with a request to bring the released reports into existing advisory and coalition spaces. Participants named legislators, the business community, and neighborhood associations as missing from the room.

Strategies

11.1 Share the findings widely. Bring the released report into existing advisory and coalition spaces, and present it at town halls and to city councils and county commissions.

11.2 Offer ongoing data education for elected officials at every level. Brief city councilors, county commissioners, and state legislators on the assessment's findings on a regular schedule, and update them as new count and service data become available, so decisions about funding and policy rest on current local information.

11.3 Develop public communications that correct common myths. Humanize people experiencing homelessness, including people with behavioral health disabilities.

11.4 Coordinate advocacy at the city, state, and federal levels. Focus on the mechanisms this assessment documented, including state policies participants described as barriers.

Action Plan

Table 47. Action plan for Priority 11, public understanding, community buy-in, and policy advocacy

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Present the released report in existing advisory and coalition spaces.	MWVCAA	Mid-Willamette Valley Homeless Alliance. Providers.	By January 2027
Prepare a short public summary and a briefing for elected officials.	MWVCAA	Mid-Willamette Valley Homeless Alliance.	First half of 2027
Agree on a shared advocacy agenda among providers before the next state legislative session.	Mid-Willamette Valley Homeless Alliance	Providers. Advocates. People with lived experience.	First half of 2027

Milestones

- Briefings reach city councils, county commissions, and state legislators in both counties.
- Providers adopt a shared advocacy agenda.

Voices to bring in. Legislators. The business community. Neighborhood associations. Police, law enforcement, and code enforcement.

14.3 Implementation Roadmap

The implementation roadmap lists all 53 actions in this plan and arranges them by when they could begin. The first seven actions fall between the release of this report and January 2027. Most are convenings. They include conversations on hygiene services and on housing access barriers, a roundtable of agency leaders, and stakeholder meetings on rural communities and on youth and families. This period also includes sharing the released report in existing advisory and coalition spaces.

The 11 actions in the first half of 2027 focus on mapping what already exists. Partners would inventory prevention, hygiene, and youth and family resources. They would also identify the shelters outside HMIS, compile local zoning barriers, and hold the first quarterly regional resource summit.

Most of the plan, 30 actions, occurs during 2027. These steps turn early conversations into shared tools and agreements, including prevention measures, data protocols, discharge agreements, and a coordinated entry audit. The final five actions are multi-year. They include new affordable housing development, changes to screening rules, and revised grant budget guidance, which take sustained effort beyond a single year.

Table 48. Implementation roadmap and actions by timeframe

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
Now to January 2027			
2	Hold conversations among shelters and providers about funding needs and partnerships for hygiene services.	The ARCHES day center (MWVCAA)	By January 2027
3	Hold a roundtable of agency leaders on shared values, collective decision-making, and collaborative funding.	Mid-Willamette Valley Homeless Alliance and MWVCAA	By January 2027
4	Host a conversation on housing access barriers.	Community partners	Within 90 days (by December 29, 2026)
8	Hold a stakeholder meeting on youth and family services, with data and education, and ask regional organizations to prioritize youth services.	MWVCAA and the Mid-Willamette Valley Homeless Alliance	By January 2027
8	Raise awareness of existing family shelter.	Family shelter providers	By January 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
9	Hold a rural stakeholder meeting that produces an action plan.	MWVCAA	By January 1, 2027
11	Present the released report in existing advisory and coalition spaces.	MWVCAA	By January 2027
First half of 2027			
1	Map current prevention resources in both counties, with funders, eligibility, and points of access.	MWVCAA	First half of 2027
2	Inventory hygiene, storage, identification, and phone resources, with hours and locations.	MWVCAA	First half of 2027
3	Schedule and hold the first quarterly regional resource summit.	MWVCAA	First half of 2027
3	Scope the capacity and eligibility directory, starting with shelter beds.	Mid-Willamette Valley Homeless Alliance	First half of 2027
5	Identify the shelters outside HMIS and what each would need to participate.	Mid-Willamette Valley Homeless Alliance	First half of 2027
6	Compile local code and zoning provisions that limit small units, single-room occupancy, RV parks, and density.	City and county planning offices	First half of 2027
7	Convene behavioral health, hospital, and shelter partners to map where people go after shelter exits and hospital discharges, and where those paths break.	Marion County and Polk County behavioral health	First half of 2027
8	Build and maintain a current catalog of youth and family resources.	MWVCAA	First half of 2027
9	Present findings at rural town halls and to city councils and county commissions.	MWVCAA regional coordinator	First half of 2027
11	Prepare a short public summary and a briefing for elected officials.	MWVCAA	First half of 2027
11	Agree on a shared advocacy agenda among providers before the next state legislative session.	Mid-Willamette Valley Homeless Alliance	First half of 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
During 2027			
1	Convene prevention partners to discuss prevention options and how organizations can collaborate.	Northwest Human Services and MWVCAA	During 2027
1	Adopt a working definition of households at risk and shared prevention measures, including housing status after assistance ends.	Mid-Willamette Valley Homeless Alliance	During 2027
1	Identify funding sources and written rules for the flexible fund.	MWVCAA	During 2027
1	Launch or expand renter education classes.	Renter education providers	During 2027
2	Identify sites and funding for after-hours and mobile hygiene services, including in rural communities.	City and county governments	During 2027
2	Work with agencies that issue identification documents on fee waivers and replacement frequency.	MWVCAA	During 2027
2	Adopt text and email notification across programs, with longer response windows.	Mid-Willamette Valley Homeless Alliance	During 2027
3	Draft a scalable coordination framework with defined roles and decision-making authority.	City and county emergency management	During 2027
3	Begin the coordinated entry fidelity audit and pilot a client status channel.	Mid-Willamette Valley Homeless Alliance	During 2027
3	Draft interagency coordination protocols and memoranda of understanding.	Mid-Willamette Valley Homeless Alliance	During 2027
4	Review program rules across shelter and housing programs and publish the results.	Mid-Willamette Valley Homeless Alliance	During 2027
4	Design the confidential domestic violence referral pathway into Coordinated Entry.	Domestic violence service providers and Mid-Willamette Valley Homeless Alliance	During 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
4	Develop landlord incentive options.	Housing authorities	During 2027
5	Build the capacity of governing bodies to create shared data protocols, including a universal release of information.	Mid-Willamette Valley Homeless Alliance board and committees	During 2027
5	Hold in-person meetings for data administrators and line staff to share practices that do and do not work.	Agency data administrators	During 2027
5	Agree on shared outcome measures, including breakdowns by race and other factors and recorded refusal reasons.	Mid-Willamette Valley Homeless Alliance	During 2027
6	Identify mobile home and manufactured housing communities at risk of closure or rising space rents.	MWVCAA	During 2027
6	Scope a one-time repair fund with existing home repair and weatherization programs.	MWVCAA	During 2027
6	Review rapid rehousing and permanent supportive housing outcomes, including returns to homelessness.	Mid-Willamette Valley Homeless Alliance	During 2027
7	Estimate the need for stabilization, specialized care, and medical respite beds.	Marion County and Polk County behavioral health	During 2027
7	Draft discharge and warm-handoff agreements.	Hospital systems and Mid-Willamette Valley Homeless Alliance	During 2027
7	Identify funding for REACH expansion and long-term operations.	REACH and its funders	During 2027
7	Offer Oregon Health Plan enrollment support at shelters and day centers.	Oregon Health Authority and the regional coordinated care organization	During 2027
8	Gather rural youth and family data and size rural shelter options.	MWVCAA	During 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
8	Review how coordinated entry works for young people, as part of the coordinated entry repair in Priority 3.	Mid-Willamette Valley Homeless Alliance	During 2027
9	Begin locally led, town-by-town data collection and a service inventory.	MWVCAA regional coordinator	During 2027
10	Develop and implement training on Tribal history, practices, and respectful engagement for staff throughout the provider system.	Mid-Willamette Valley Homeless Alliance	During 2027
10	Review language access and culturally responsive service availability across shelters and coordinated entry.	Mid-Willamette Valley Homeless Alliance	During 2027
10	Culturally specific organizations identify the agencies and systems they want to meet with.	Culturally specific organizations	During 2027
10	Invite The Confederated Tribes of Grand Ronde and The Confederated Tribes of Siletz Indians to shape the Tribal engagement pathway.	MWVCAA	During 2027
Multi-year			
2	Collect feedback from people who use these services to track whether access grows.	Shelters and day centers	Multi-year
4	Pursue ban-the-box and credit screening changes for rental applications.	Advocates	Multi-year
5	Revise grant budget guidance to cover staffing, supervision, wellness, and peer positions.	Funders	Multi-year
6	Pursue new deeply affordable and small-unit development.	Housing authorities and affordable housing developers	Multi-year
9	Design and fund local services in communities ready to host them.	Rural providers and city governments	Multi-year

14.4 What Community Members Told Us to Do First

Listening session participants were asked to name one change that would make a difference. Their answers, listed here in order of frequency, describe basic infrastructure more often than programs or services.

- **Public restrooms that are clean and open after 10 p.m.** *"Public restrooms that are clean and decent for you guys to use, and not have a lock on them." "I would like them to put more bathrooms in that are open late, because after 10 o'clock there's no restroom."*
- **Showers.** Participants described improvising through friends, a funeral home, or the river.
- **Laundry.** *"There is no laundromat in this town. Where are we supposed to do laundry?"*
- **Drinking water.** *"There's nowhere to get water. I have to go find a faucet."*
- **Trash disposal.** *"There's not enough trash bins anywhere. I walk for blocks sometimes just to throw something away."* Participants noted that bins are removed after housed residents dump furniture in them.
- **Lockers and storage.** Participants described being unable to attend court, appointments, or interviews while carrying everything they own, and unable to leave belongings anywhere without losing them.
- **Safe, legal places to park or camp.**

Beyond the infrastructure requests, participants asked for three changes to how the system works. They asked for replacement identification and documents to be free and available as often as needed, since documents are lost to sweeps, theft, and weather more than once a year. They asked for the chance to explain a decades-old conviction to a person rather than be screened out by a form. They asked for rent that matches income or income that matches rent. And in every session, in different words, they asked to be treated as a person by clinicians, police, landlords, employers, and front-desk staff.

Table 49. What participants asked for, by listening session

Session	What participants asked for
Session 1, Salem	• Bus passes for people with no income • A laundry assistance program • Cleaner and more frequently serviced public restrooms • Faster unemployment and benefit decisions • Lockers • Help for young people facing barriers
Session 2, Salem	• 24-hour clean public restrooms • Safe legal parking with a shorter application • Lockers and storage • A self-governed pilot community on public land • Places that allow pets and partners • Advocacy and guidance to navigate Section 8 vouchers • Investigation of where funding goes • To be treated "like a human, like any other human"

Session	What participants asked for
Session 3, Salem (youth)	• Free or far cheaper replacement ID, birth certificate, and Social Security card, with no voucher cap • Free or affordable health care • Affordable apartments • Better and safer shelters • Diapers, formula, and period products • Easier access to housing for people with criminal records • Someone trusted to talk to • Better mental health support
Session 4, Monmouth	• Lower rents and more affordable housing • Use of on-site shelter vehicles for resident appointments • Reliable laundry • Better counselors and therapists locally • Use of empty buildings for housing • A community workshop or garage where people can build • An end to judgment and stereotyping • A cleaner river
Session 5, Stayton	• More bathrooms open late • Drinking water • Day work available in short shifts • A legal camping area with a kitchen, bathrooms, and a small nightly fee, self-monitored by residents • Parking permits • An online wish list so the community can donate directly • Ban-the-box on rental applications • Know-your-rights training • Mental health resources • Changes to bottle and can redemption limits
Session 6, Providers (virtual)	• Rental assistance and homelessness prevention funding • Affordable housing for low and fixed incomes • Services for families, particularly single fathers • Animal care resources • Paid self-care time built into staff hours • A quarterly regional resource summit • A shared communication platform that is not HMIS • Live shelter bed availability
Session 7, Falls City	• More affordable housing • A laundromat • A grocery store • Local job opportunities • Electronic rather than mail-only housing paperwork • Reliable mail delivery

Session	What participants asked for
	• SNAP that does not cut off at the first raise
Session 8, Silverton	• Remove or limit background checks for jobs and apartments • Shorter housing voucher waits • Lower rents • Reduce overall cost of living • Disability-accessible service navigation • Qualified ASL interpreters • Affordable cars, bikes, and e-bikes • Help replacing vital documents • Credit history protection during homelessness • Hygiene items covered by SNAP • Job training for entry-level roles • More shelters like this one • Trauma-informed schools, clinics, and police

Note. Requests as recorded in each session's transcript and written packets. Items within each session are listed as raised, not by frequency.

> *"Stop counting us like sheep, and then turn around and go, oh, we've got these many people, we need money, and then take that same money and put it somewhere else."*
>
> Community Member Listening Session, Salem
>
> *"What I need? I need for someone to believe in me."*
>
> Community Member Listening Session, Silverton

15. Conclusion

This community needs assessment set out to describe homelessness in Marion and Polk Counties. Most people experiencing homelessness in the region had lived there for years before losing their housing. Forty-two percent of survey respondents grew up in the area or had lived there more than ten years. For most, the current episode is not their first, and prior episodes recurred or ran long. Housing loss most often followed several events at once, arriving on incomes the regional housing market does not support.

The regional sheltering system holds 44 programs, a workforce drawn substantially from lived experience, peer support capacity in three-quarters of organizations, and near-universal health coverage among the people it serves. The same system's counted capacity exceeds its usable capacity, its rules exclude identifiable groups, its information does not reach the people seeking help or the workers providing it, and the harms it produces fall most heavily on the people exposed to it longest.

Most people who are now homeless received no prevention support before losing housing, and the households now at risk cite that support as what they need. Not knowing what exists is a barrier comparable in scale to the shortage of what exists. The supports people credited most often were relationships with specific people, and the harms they named most often were program rules. The system lacks an unduplicated count, a shared wait-time definition, outcome analysis by race, and any channel through which a waitlisted household can learn where it stands.

The last words are from some of the participants who insights informed this report. When asked what life looks like a year from now if everything works out, participants said the following:

> *"I want to restore my family. I'm working with DHS to get my kids. And I want to give back to those that are in my position."*
>
> Community Member Listening Session, Silverton
>
> *"I'm gonna start taking the business courses for hotel management... The reason I'm taking this is I want to build an RV park... and I want to build myself a campground, and I want to build a homeless shelter to help other people."*
>
> Community Member Listening Session, Woodburn
>
> *"Coming home from work to my kids, my wife."*
>
> Community Member Listening Session, Salem
>
> *"Working, in a house, and a big ol' dog."*
>
> Community Member Listening Session, Salem

> *"This issue is solvable. It's realistic to help people. It's realistic that people can get affordable housing and stay housed. It just needs to be made possible for us to do our jobs."*
>
> Service Provider Listening Session

HOUSING & HOMELESSNESS COMMUNITY NEEDS ASSESSMENT

Sheltering Services in Marion & Polk Counties

A Landscape Scan and Gap Analysis

PREPARED FOR

Mid-Willamette Valley Community Action Agency

PREPARED BY

Woodson Insights Research + Evaluation

DATE

September 2026

SHELTERING SERVICES IN MARION AND POLK COUNTIES: A LANDSCAPE SCAN AND GAP ANALYSIS

Background

Marion and Polk Counties have seen sustained growth in homelessness and housing instability in recent years, and the region's response is delivered by a constellation of public, nonprofit, faith-based, and Tribal providers that largely operate independently of one another. The Mid-Willamette Valley Community Action Agency (MWVCAA) commissioned this Housing and Homelessness Community Needs Assessment to build a clear, shared picture of that response and to inform its regional planning. As the agency works to coordinate resources and prioritize investments across the two counties, it needs a current accounting of what sheltering capacity exists, where it is located, whom it serves, and where the most significant gaps remain. Woodson Insights Research + Evaluation (Woodson Insights) conducted a landscape scan of sheltering services for people experiencing homelessness in Polk and Marion counties from March through May of 2026. The landscape scan was the first in a series of evaluation instruments to comprehensively assess community sheltering needs in the region.

With a growing number of people experiencing housing instability in the region, this landscape scan is a key part of understanding both the geography and capacity of existing sheltering services, as well as the available services and populations served.

The landscape scan was designed to answer three key evaluation questions:

1. What sheltering services currently exist to address homelessness in Polk and Marion counties?
2. What are the gaps in sheltering services for people experiencing homelessness in the region?
3. What barriers are there to accessing sheltering services?

Subsequent evaluation instruments that are part of this ongoing community needs assessment will amplify our understanding of the strengths and weaknesses of the current sheltering system, as well as barriers that real people are experiencing on the ground. Ongoing research methods include a series of community member and service provider listening sessions, in addition to surveys for both service providers and people accessing sheltering services.

This report focuses specifically on sheltering programs, defined as the emergency, low-barrier, warming and cooling, transitional, Permanent Supportive Housing, recovery-focused, day-center, and rapid-rehousing programs that make up the region's sheltering continuum. It does not attempt to inventory the broader network of food, health, employment, and other supportive services that people experiencing homelessness also rely on. Those services are an important part of the regional landscape and are best examined in their own right. By concentrating on sheltering capacity, this gap analysis establishes a foundation that the surveys and listening

sessions in later phases of the assessment will build on with the lived experience of community members and providers.

Methodology:

The landscape scan was organized around a structured shelter inventory instrument that captured each program's organization and populations served, shelter type, capacity, operating hours, eligibility and access requirements, outreach methods, and funding. The full set of questions appears in *Appendix D*. Woodson Insights compiled an initial list of sheltering programs operating in Marion and Polk Counties in coordination with MWVCAA and refined that list throughout data collection as programs were confirmed, consolidated, or determined to be outside the scope of sheltering.

This landscape scan provides a program-level overview of all 44 shelter and housing programs included in the 2025 MWVCAA Homelessness Needs Assessment landscape scan for Marion and Polk Counties. Verification followed a tiered approach. Every program began with internet research, followed where possible by a brief confirmation call with staff, a more in-depth conversation by phone or email with program leadership, and a final email confirmation of the recorded details. *Appendix E* documents which verification steps were completed for each program. Not every program completed every step, and the depth of verification varied with each provider's availability and capacity to respond.

Limitations:

Self-reporting and verification. This landscape scan reflects program-level data that was largely self-reported by shelter providers and verified by phone and email where possible. Gathering complete and consistent information from busy frontline providers was an inherent challenge. Understandably, program staff balance data requests against the immediate demands of operating a shelter. Some information (like cost per bed and the number of unique individuals served) programs do not routinely track. In several cases, different contacts within the same organization provided different figures. Rather than treating this as error, we read it as a sign that these organizations are continually adapting to changing need, so that capacity and availability are better understood as a moving target than as fixed counts. The figures in this report reflect the best available information at the time of collection between March and May of 2026.

Uneven reporting. Reporting was uneven across several key metrics, which limits the conclusions that can be drawn at a system level. Average operating cost per bed was reported by only 15 of 44 programs, and those figures reflected different underlying definitions, as described in *Finding 27*. The number of unique individuals served annually was reported by 28 of 44 programs, bunk and congregate bed counts were reported inconsistently, and five programs did not report operating hours at all.

Households vs. individuals served. Because family-serving programs report capacity in households rather than individual beds, combined capacity estimates rely on a conservative

conversion of three individuals per household (as described in the *Definitions* section) and should be read as estimates. The region also lacks the infrastructure to produce a system-level unduplicated count. HMIS allows deduplication at the county level but not the program level, and 13 programs do not use HMIS at all, so the reported sum of unique individuals served should not be interpreted as the number of distinct people the system reaches.

Reported need vs. capacity. The Point-in-Time Count, the annual one-night census of people experiencing homelessness, is widely understood to undercount the true scale of homelessness and need.[1,2,3] It misses people who are doubled up with friends or family, sleeping in vehicles or other locations that enumerators do not reach, or otherwise out of view on the night of the count. As such, the level of need this report compares capacity against should be read as a conservative floor rather than a complete picture. Reported capacity comes with its own limits, because a bed that exists on paper is not necessarily a bed a given person can use. Eligibility restrictions reserve many beds for specific groups, so a women-only or veterans-only bed is not available to someone who does not qualify. Geographic access matters as well, since a bed in Salem does little for someone in rural Polk County without transportation to reach it. And real-time availability fluctuates, so a bed counted in the inventory may be occupied, waitlisted, or offline on any given night. For these reasons, capacity should not be read as simply the number of people the system is able to shelter. The gap between need and usable capacity is wider than a direct comparison of totals beds to total need would suggest.

Equity and equitable access. Certain dimensions central to equity and equitable access could not be fully captured in this landscape scan. Most programs reported that they are not culturally specific and serve all races and ethnicities, with only a few serving a specific community, so the scan reflects whom programs are designed to serve rather than the demographic makeup of the people they reach. Physical accessibility accommodations were reported by only a minority of programs, and the system contains no LGBTQIA+ specific programming, which limits what the scan can say about how well it reaches these communities.

Definitions:

The definitions below clarify how key terms are used consistently across this report.

Beds and households. Family-serving programs predominantly report capacity in households rather than individual beds, reflecting the reality that family shelter is unit-based. Reporting often requires data to be in the form of total beds or sleeping spaces, which requires either a conversion assumption or a separate data collection effort to determine average household size

[1] U.S. Government Accountability Office. (2020). *Homelessness: Better HUD oversight of data collection could improve estimates of homeless population* (GAO-20-433). https://www.gao.gov/assets/gao-20-433.pdf
[2] National Alliance to End Homelessness. (n.d.). *What is a point-in-time count?* Retrieved June 24, 2026, from https://endhomelessness.org/resources/policy-information/what-is-a-point-in-time-count/
[3] Schneider, M., Brisson, D., & Burnes, D. (2022). The annual homeless point-in-time count: Limitations and two different solutions. *American Journal of Public Health, 112*(4), 545–547. https://doi.org/10.2105/AJPH.2021.306640

and bed counts per unit. For combined bed counts, we calculated a conservative value of three beds per family unit.

Bed / Individual Bed	Signifies a shelter bed or sleeping space meant to accommodate one person. May include congregate beds, bunk beds, beds in private housing units or single occupancy rooms, depending on the shelter.
Household / Family Unit	Signifies a family with or without children, or a group of individuals who are living together as one economic unit. Some shelters in the landscape scan track capacity by "families" rather than "beds" because they offer private family rooms or housing units meant to accommodate a group. The number of beds vary in these instances, depending on the size of the family seeking shelter but are typically 3-5 beds.

Shelter types. Providers self-identified from the following shelter types and were able to designate multiple shelter types for one location.

Emergency shelter	Short-term, overnight accommodation for individuals or families in crisis who have no immediate place to stay. Focused on immediate safety and basic needs like a bed, meals, and hygiene.
Low-barrier shelter	Shelters with minimal preconditions to access services, such as sobriety requirements, ID, or curfews, in order to reach people who might otherwise go unsheltered.
Warming/cooling shelter	Temporary, often seasonal shelter activated during extreme weather (heat waves or freezing temperatures) to protect unsheltered individuals from life-threatening conditions. May operate out of churches, community centers, or other public spaces.
Transitional housing	Time-limited housing (typically up to 24 months) that provides a structured, stable environment between emergency shelter and permanent housing, often paired with intensive supportive services to help residents build skills and self-sufficiency.
Permanent Supportive Housing	Long-term, stable housing combined with ongoing voluntary supportive services, designed primarily for individuals with chronic homelessness or disabilities. There is no time limit on tenancy.

Day center	A daytime-only facility where unsheltered individuals can access basic needs and services — such as showers, laundry, meals, mail, phone charging, and case management — without requiring an overnight stay.
Recovery-focused shelter	A shelter specifically designed to support individuals in recovery from substance use disorders, typically maintaining a sober environment and offering structured programming, peer support, and connections to treatment services.
Rapid Rehousing	A short-term intervention that quickly moves individuals and families into permanent housing through a combination of housing search assistance, temporary rental assistance, and case management support.

Primary populations. Providers self-reported the number of beds/family units at their shelters as well as populations served. We then designated each shelter as serving a primary population (Survivors of DV, Youth, Adults Only, Adults with Children) based on their response. Some programs reported serving multiple populations, in which case we designated the primary population based on the definitions below.

Beds for Survivors of DV	Beds are dedicated to survivors of domestic violence, sexual assault, human trafficking or stalking. Not all people who seek shelter in these instances are currently experiencing homelessness, but they do have housing instability and safety concerns due to a DV situation.
Beds for Youth	Beds are dedicated to youth ages 11-17 only. These shelters often also serve survivors of DV in a mixed shelter environment.
Beds for Adults with Children	Beds are open to adults 18+ and their minor dependents. In some cases, these beds may also be open to adults without children and survivors of DV in a mixed shelter environment
Beds for Adults Only	Beds are dedicated to adults 18+ only. These shelters often also serve survivors of DV and veterans in a mixed shelter environment.
Beds for Veterans	Beds are dedicated primarily to veterans.

Key Findings:

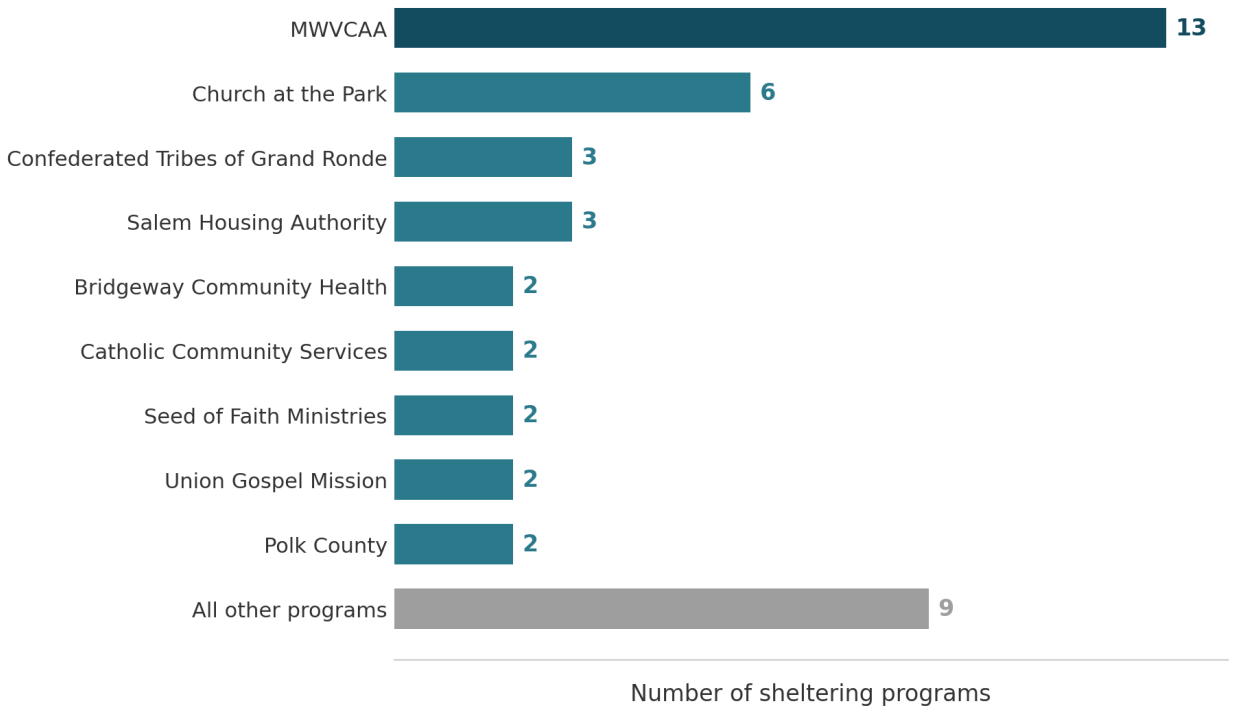
Section 1: Assessing the scale and capacity of shelters in Marion and Polk Counties.

FINDING 1: The Marion/Polk region is home to 44 sheltering programs for people experiencing homelessness, operated by 18 independent organizations.

The region relies on 18 different organizations to shelter people experiencing homelessness, yet only a handful operate most programs. MWVCAA operates 13 programs, accounting for 30% of all sheltering programs. Church at the Park accounts for the next largest share, operating six programs. Tribal organizations are also making important contributions to shelter capacity with Confederated Tribes of the Grand Ronde operating three verified shelters.[4] Together, these organizations operate more than half of all sheltering programs in the region.

Figure 1

Share of Sheltering Programs Across Organizations



[4] *NOTE: Confederated Tribes of Grand Ronde and Confederated Tribes of Siletz also operate two transitional living centers each — four total — which were not included in this count because bed data was not verified.

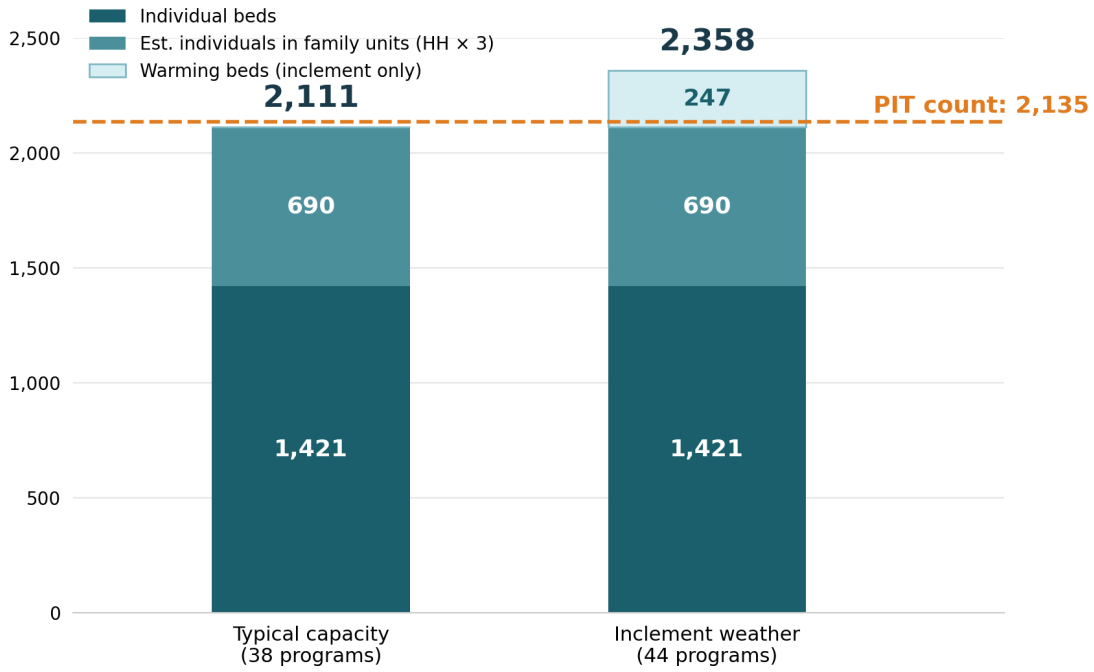
FINDING 2: The region's shelter capacity falls short of meeting the 2,135 beds needed for unhoused individuals on a typical night — but that doesn't tell the whole story.

The most recent official Point-in-Time (PIT) Count for the Marion and Polk County region (conducted in January 2025) identified 2,135 individuals experiencing homelessness. This included 953 unsheltered individuals and 1,182 sheltered residents. At that time, nearly half were experiencing homelessness for the first time.[5] At the system's current typical capacity of 1,421 individual beds and 230 family units (approx. 690 individuals), shelter beds still come up 24 beds short. This gap is filled during inclement weather when an additional 247 beds become available. However, considering that **total bed counts do not account for eligibility restrictions, geographic access or other barriers, we can't assume the current shelter capacity is sufficient to meet sheltering needs in the region**. Point-In-Time Count data also often undercounts individuals experiencing homelessness, which means the number of people in need of shelter is likely higher in the region.

For a more detailed breakdown of bed capacity see Appendix A.

Figure 2

Shelter Capacity vs. Population Experiencing Homelessness



[5] McDonald, A. (2025, May 5). Record number of homeless people counted in Marion, Polk counties. *Salem Reporter*. https://www.salemreporter.com/2025/05/05/record-number-of-homeless-people-counted-in-marion-polk-counties/

Typical capacity	Inclement weather capacity
2,111	**2,358**
24 below PIT · 99% coverage	+223 above PIT · 110% coverage
38 programs · 1,421 beds · 230 HH	44 programs · 1,668 beds · 230 HH

Notes: Est. individuals in family units = 230 households × 3 individuals per unit (this is conservative and could be up to 5 individuals per unit). Warming beds add 247 spaces during inclement weather across 5 programs (ARCHES Day Center, 30 beds; ARCHES Woodburn, 20 beds; Seed of Faith, 80 beds; ARCHES Salem First Presbyterian, 97 beds; Polk County Warming Centers, 20 beds). Surplus combined capacity does not mean all individuals are sheltered — PIT counts undercount actual homelessness and reported capacity does not account for eligibility restrictions, geographic access, waitlists, or program-specific barriers.

FINDING 3: Data collection gaps limit system-level understanding of program reach.

Most programs in Marion and Polk Counties track how many “unique individuals” they serve, which is the starting point for understanding the system's annual reach. As part of this landscape scan, **28 of 44** programs (**64%**) reported the number of “unique individuals” they serve annually, totaling **8,345** individuals.

That total is best understood as a measure of scale rather than a precise count of distinct people, because of how it is assembled. A person who moves through more than one program in a year may be counted in each of those programs' totals. At the same time, **16 programs did not report a “unique individual” count**, so some of the people the system serves are not represented in the 8,345. Taking both of those factors into account, the figure tells us the system serves people on the order of several thousand each year.

A shared system for matching records across programs already exists, and most programs are part of it. **31 of 44 programs (70%)** participate in the Homeless Management Information System (**HMIS**), the shared database that allows the same individual to be recognized across participating programs within a county. That is a strong base to build on. Producing a true unduplicated count would mean running the reported figures through that matching process and bringing the remaining 13 programs into a shared reporting approach, so that each person the system serves is counted once and counted accurately. The 13 programs that do not use HMIS represent a meaningful blind spot. This tells us the region does not currently have the ability to accurately answer the question of how many people its shelter system reaches each year. And, with 16 programs not reporting unique individuals for this report, it is difficult to draw meaningful conclusions about who is currently being served across the housing continuum.

Figure 3

“Unique Individuals” Served Annually

8,345	28 of 44	31 of 44
Sum of “unique individuals” served across programs*	programs reporting	use HMIS

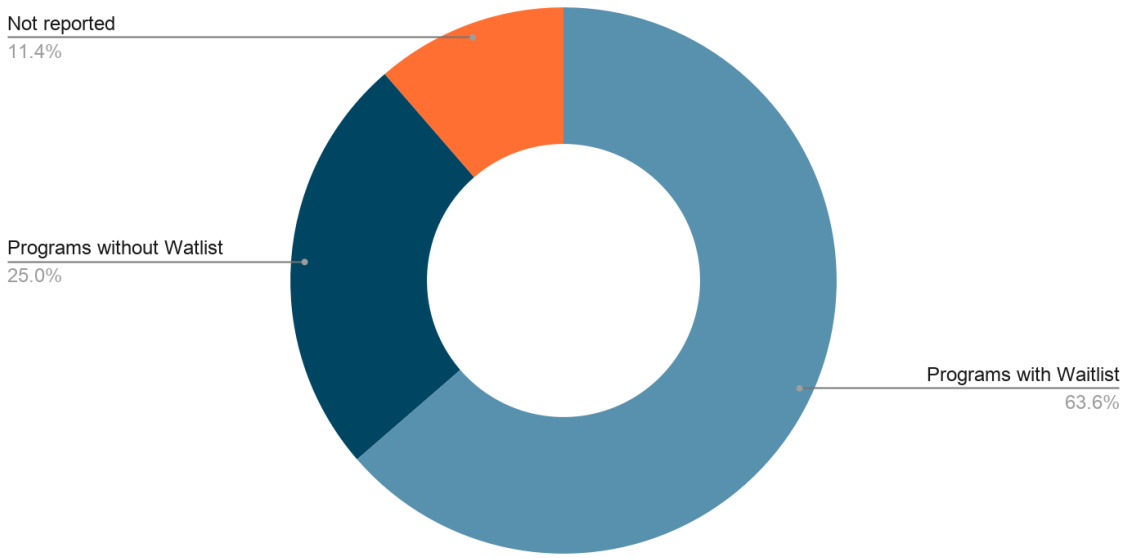
* Reported individuals should not be interpreted as unduplicated system reach. “Unique individuals” reported are unduplicated within each program, but not across programs.

FINDING 4: Most programs report operating at or near capacity with waitlists.

The region's shelter capacity is in nearly constant use across the continuum. **28 of 44 programs reported maintaining a waitlist.** The term is applied loosely, since some programs treat a waitlist as confirmation that they are full while others use it to manage the one or two beds that turn over on a given night. The current data does not capture how long any individual waitlist is. The consistent picture is one of very little open capacity at any single point in the system — across shelter types and populations served.

Figure 4

Waitlist by Program



Use of waitlists is pervasive across the system, **much more common among low-barrier shelters** (88% have waitlists) when compared to higher barrier options (50% have waitlists). When we look at wait lists by primary population served, 68% of adults only programs have waitlists and 78% of programs for adults with children. Notably, shelters for survivors of DV do not operate traditional wait lists — both operate on walk-in, hotline, and safety-need basis. Of the two youth programs, David's House reports using a waitlist.

The pressure is easiest to understand by following it through the shelter continuum. Permanent Supportive Housing runs at or near **100%** occupancy with very low turnover, which is expected for a model designed to be a long-term home rather than a temporary stop. Transitional housing is nearly as full, with **11 of 15** programs operating a waitlist. Because these long-term options rarely open up, people ready to move out of emergency shelter stay longer. That keeps emergency shelters full, **10 of 15** of which are at capacity, and leaves the low-barrier shelters that serve as the system's front door almost entirely occupied. When the back of the system does not move, the front cannot either.

How those beds fill also shapes who can reach them. Several of the low-barrier programs, including ARCHES Lodge for veterans, ARCHES Inn for adults, and the Salem Navigation Center for adults, fill openings through **Coordinated Entry**[6] — so a bed becoming available does not mean a person can walk in and claim it that night. A few programs do maintain genuine open-door availability and report no waitlist: Taylor's House for youth, the Center for Hope and Safety and Sable House for survivors of domestic violence, and Men's Mission for men. Together these offer the most dependable walk-in emergency options in the region, though each serves a specific population. Warming sites likewise report no waitlists, though they operate only a handful of nights per year during severe weather.

The thinnest point of open access is for families with children, where only **five family units** were available at the time of reporting. Importantly, this family unit count does not include short-term hotel stays, which some providers (like Center for Hope and Safety) offer to families in crisis. Family-friendly capacity is there, but available family units are limited — meaning a family arriving in crisis may have fewer immediate options.

Because programs define and track waitlists so differently, the region can see that demand is outpacing available beds but cannot yet measure the size of that gap or how long people wait. A shared definition of what counts as a waitlist, paired with a simple record of its length, would turn this from something the system observes into something it can measure and plan around.

FINDING 5: Programs report a range of average stay lengths for residents, with most beds available only short term.

Of the 44 shelters in operation, 39% (17 programs) reported an average length of stay of **up to three months**. Among those short-term stays, the majority fell within the "up to one month" range. This includes emergency shelters reporting a "30-day recertification," which means the actual average stay is usually longer than 30 days. Shelters operating as warming and or overnight centers were the only ones to report **single-night stays**. Twenty-two percent (10 programs) reported mid-range stays of **six months to one year**, and 18% (8 programs) reported longer stays of **two years and beyond**. The remaining 9 programs (21%) did not report an average length of stay, either because the measure does not apply to their model or because it was left blank.

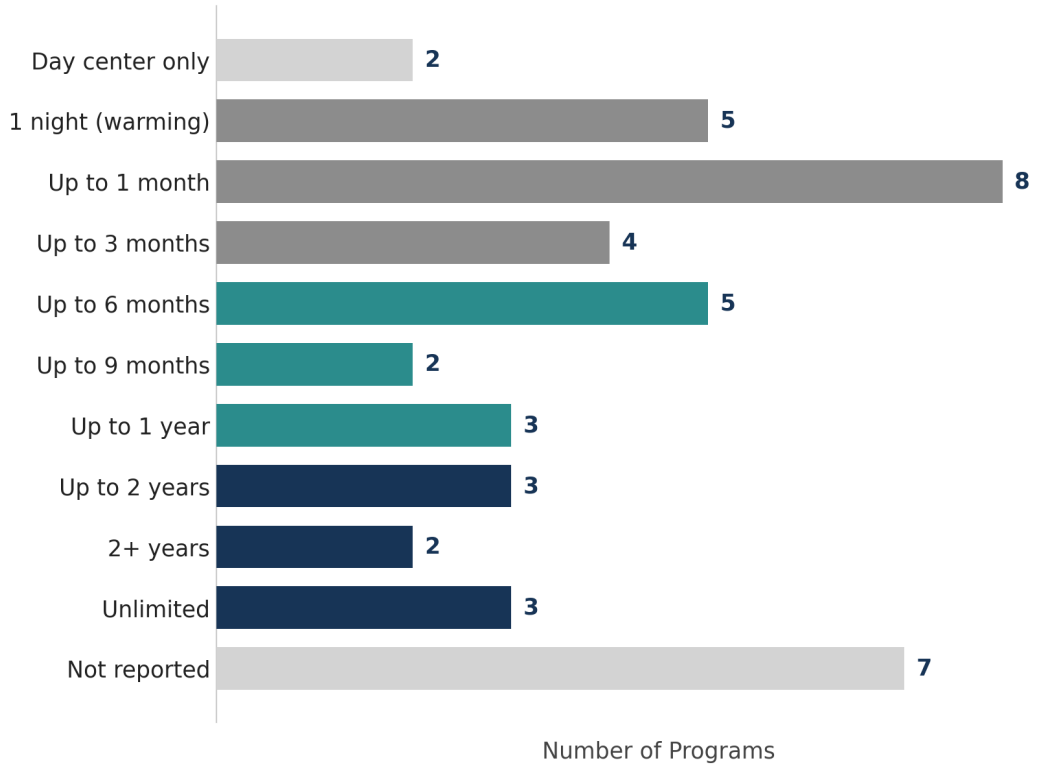
Stay length also shapes how quickly beds become available to the next person. Permanent Supportive Housing predictably reports the longest stays, with most being "unlimited." This fits a model designed to be a long-term home with very little turnover. **Emergency shelters showed the widest spread, from 30 days up to 9 months.** Center for Hope and Safety, Men's Mission, and Sheltering Silverton reported the longest stays in this category, indicating they may be operating more like transitional housing in terms of stay duration. Where emergency stays

[6] Rather than a first-come, first-serve model, Coordinated Entry is a local, centralized system that gives people a single, fair way to find and enter shelters without calling every provider. Participating providers used a shared assessment to understand the unique needs of each person and find the best fit for their situation.

stretch this long, beds open up slowly, which connects directly to the limited availability described in *Finding 4*.

Figure 5

Shelter Programs by Average Length of Stay



Note: Bar color reflects length of stay, with grey for short stays (one night to three months), teal for mid-range stays (six months to one year), and navy for long-term stays (two years or more). Day center only and Not reported, shown in light grey, are not duration categories.

FINDING 6: Shelter capacity is concentrated at the edges of the continuum.

The system is strongest at the two ends of the continuum, emergency and crisis sheltering and, to a lesser degree, long-term housing. It is thinnest in the transitional and bridge housing that moves people from shelter toward stability. Because programs self-identify with more than one shelter type, these categories overlap and should be read as descriptive rather than additive. The largest pool of individual beds operated by a single organization is at those with **low-barrier designation only**, with 311 beds across 5 programs, all run by MWVCAA through the ARCHES network. Including **all shelters with a low-barrier designation** (even if they also identify with other shelter types) brings that total to 681 beds and 70 households. A total of 829 beds and 77 family units are categorized as **emergency shelter** across 15 programs that vary widely in size, philosophy, and eligibility. At the long-term end, **Permanent Supportive Housing** accounts for 65 individual beds (6 of which are recovery-based at Redwood Crossings) and 112 family units, all with very low turnover.

The transitional middle is comparatively thin. **Transitional housing** accounts for 295 beds and 41 households combined, spread across 15 programs, many of them small and population specific. Bridge options that would speed movement out of shelter, whether transitional housing or rapid rehousing, are limited, and rapid rehousing appears at only two programs. For an individual ready to leave emergency shelter for something more stable, the pipeline forward is narrow, which means people stay in emergency and low-barrier beds longer and those beds turn over more slowly, the same pressure described in the length-of-stay and waitlist findings. It’s worth noting that what little transitional capacity exists is heavily weighted toward programs with eligibility requirements, not low-barrier options. Only three programs are low-barrier in the transitional housing space: SafeSleep and Family Promise operate primarily as emergency shelter programs with a transitional component, which means Lupe’s House (9 beds) is the only dedicated low-barrier transitional housing option.

Family unit capacity follows a different pattern, weighted toward longer-term housing with low turnover. Emergency family capacity exists, but those programs are more likely to carry waitlists, so families in immediate crisis have limited walk-in options.

Since many programs serve more than one function, this figure groups individual beds by each program's full combination of self-identified shelter types rather than by a single category. A program that operates as both an emergency and a low-barrier shelter, for example, appears under that combined label rather than being split between the two. This approach avoids double-counting beds, but it makes these categories more granular than the broader groupings used elsewhere in this chapter, so the two should not be compared directly or added together. Read this way, the figure shows that the largest concentrations of beds sit in emergency- and low-barrier-oriented programs, while Permanent Supportive Housing and the various transitional combinations each account for a relatively small share.

Figure 6.2 disaggregates the region's 230 family units (households) by each program's combined shelter type, in the same way as the companion individual-bed figure. Permanent Supportive Housing (PSH) holds the most family capacity, with 112 households in PSH alone, all of it long-term placement with low turnover. In short, families have meaningful long-term and low-barrier capacity but very little stand-alone emergency capacity.

Figure 6.1

Individual Bed Capacity by Combined Shelter Type

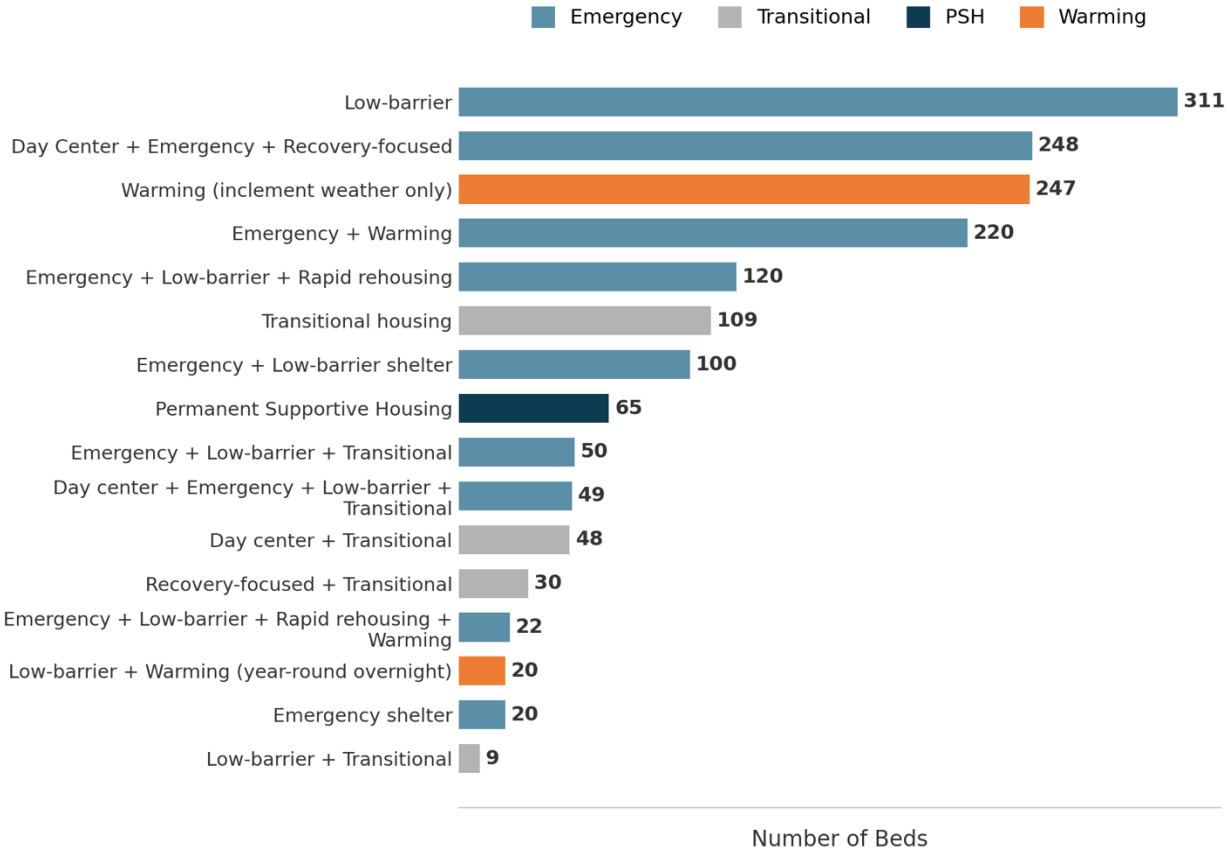
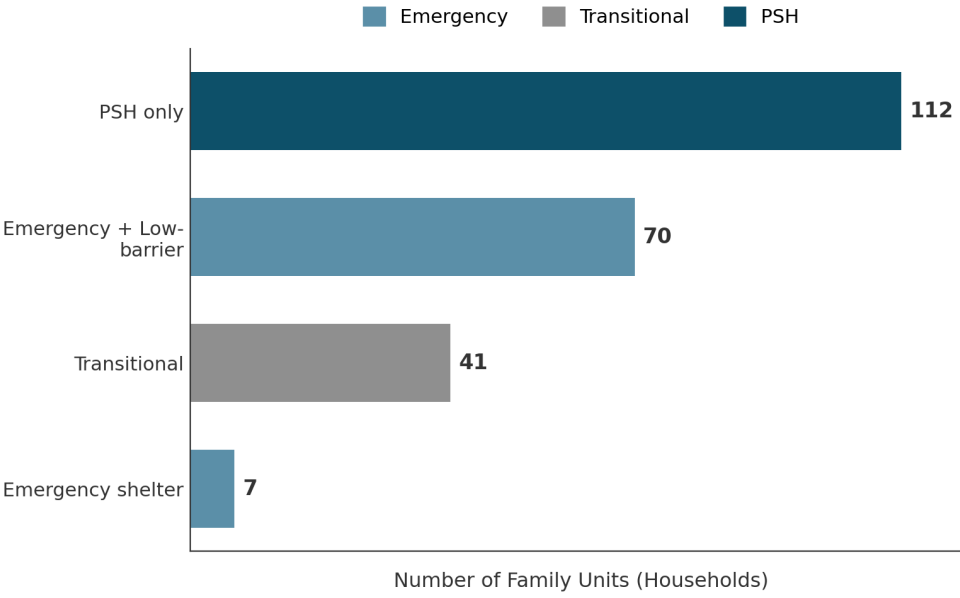


Figure 6.2

Family/Household Unit Capacity by Combined Shelter Type



FINDING 7: Bed capacity falls short of 2025 Point-In-Time Counts, except for veterans and adults with children.

Almost half of all individual beds (48.1%) are designated for **adults only, single individuals without children.** This capacity is anchored by a small number of large programs, most notably the ARCHES network and Men's Mission, which account for most adult-only beds. These programs provide meaningful scale, but their concentration in Salem means adults experiencing homelessness in rural Polk County have fewer options, unless they are willing to travel. As shown in Figure 7, the 2025 Point-in-Time Count[7] identified 1,700 adult individuals experiencing homelessness across the two counties. When we compared with 683 available beds for "adults only," that's a gap of 1,017 beds. Depending on their needs and lived experiences, however, some adults could also find DV-only beds (130 beds) or Veteran-only beds (119 beds).

Families are counted primarily in household units rather than individual beds — 91.7% of all household units and 31.9% of beds are dedicated to **adults with children** across 17 programs. The 2025 Point-In-Time Count identified 122 unsheltered and sheltered family households (419 people). When compared with 211 household units of capacity and an additional 453 individual beds, there appears to be an oversupply. However, nearly half of the household units (112) are held in Permanent Supportive Housing and individual beds are not guaranteed to offer the privacy many families need, even if these shelters are open to accompanied children.

The two subpopulations with the least dedicated capacity — **youth and survivors of domestic violence** — are also among the most vulnerable, and the Point-In-Time Count data makes the gap concrete. It is worth noting that the landscape scan and the Point-In-Time Count define youth differently: the scan uses ages 11–17, while HUD's Point-In-Time methodology extends unaccompanied youth through age 24. Treating these as two distinct groups produces a clearer picture of both supply and need.

Dedicated **minor youth** capacity (ages 11–17) totals just 20 beds across two residential programs of 10 beds each: Taylor's House in Salem and David's House in Monmouth. The 2025 Point-In-Time Count identified 16 unaccompanied children under 18, appears to match available beds. However, unaccompanied minors are among the hardest populations to reach in a single-night survey, which makes undercounting likely. Although the total is very small, the two residential programs place one in Marion County and one in Polk County, so youth shelter is not confined to Salem.

Young adults ages 18–24 face a clearer and more measurable gap. Two programs serve this age group with dedicated or near-dedicated capacity: Young Adult Shelter Community (YAS), operated by Church at the Park, provides 22 beds across 19 household units, and HOST provides 16 transitional beds — a combined total of 38 beds. The 2025 Point-In-Time Count identified 88 unaccompanied young adults ages 18–24, leaving a gap of roughly 50 beds. Unlike

[7] As provided by Mid-Willamette Valley Homeless Alliance, *2025 Point-in-Time (PIT) Count Summary Report, OR-504: Salem/Marion, Polk Counties Continuum of Care* (count conducted January 22, 2025), https://mwvhomelessalliance.org/wp-content/uploads/2026/07/2025-PIT.pdf.

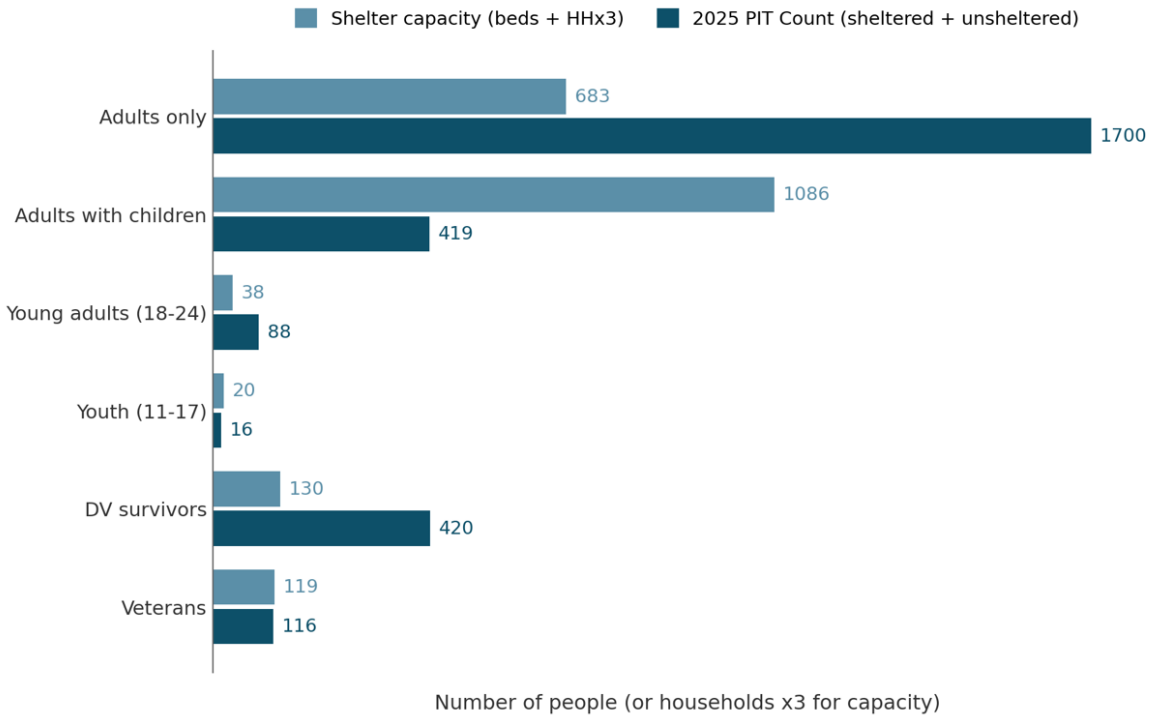
minor youth, young adults ages 18–24 are generally absorbed into adult programs across the broader system, but often without dedicated services tailored to their circumstances.

Survivors of domestic violence are served by only two dedicated programs totaling 130 beds: Center for Hope and Safety in Salem (120 beds) and Sable House in Dallas (10 beds). The 2025 Point-In-Time Count identified 420 adult DV survivors experiencing homelessness compared with 130 dedicated beds. This is the largest gap of any subpopulation. Center for Hope and Safety also offers emergency short-term hotel stays throughout the state, offering some flexibility for those in rural areas. Ten additional programs list DV survivors among the populations they serve, though without the specialized services that dedicated programs provide. For both DV survivors and youth, the very small number of dedicated providers means that a single closure, a waitlist, or a geographic mismatch can leave a highly vulnerable person with no dedicated option within reach.

Veterans are a notable exception to the pattern of undersupply. The region's three veteran-specific programs — ARCHES Lodge, VETCare Veterans Home, and Gale's Lodge — together provide 119 beds against 108 veterans identified in the 2025 Point-In-Time Count, a near-exact match without accounting for potential undercounts.

Figure 7

Supply and Demand: 2025 PIT Count vs. 2026 Capacity



Notes. *Population designations reflect "primary population" served. Some programs reported serving multiple populations, in which case a primary population was designated based on definitions provided earlier in this report. Beds = non-inclement individual sleeping spaces + household units multiplied by 3. Data based on January 2025 PIT Count Data as published at MWVHA: https://mwvhomelessalliance.org/wp-content/uploads/2026/07/2025-PIT.pdf*

Table 7

Dedicated Bed/Household Capacity by Population Served (No Inclement Weather)

Population	Programs	Beds	% of Beds	Household Units	% of Units	Program Names
Adults only (18+)	12	683	48.1%	0	0%	ARCHES Inn · Salem Navigation Center · Men's Mission · Coral Women's House · Monmouth Adult Shelter · Village of Hope (VOH) · ARCHES Woodburn · Village One · CRAWL · Lupe's House · Women at the Well Grace House · Redwood Crossings
Adults with children	17	453	31.9%	211	91.7%	Family Promise · Family Shelter Community (CCS) · Sequoia Crossings · Yaquina Hall · Village Two · Seed of Faith · Simonka Place · SafeSleep United · Sheltering Silverton · ARCHES Nest · St. Francis Family Housing · Family Site Dallas House · Warriors of Hope · Father Taaffe Homes · New Options · Ediger Hall · St. Joseph Family Shelter
Survivors of domestic violence only	2	130	9.1%	0	0%	Center for Hope and Safety · Sable House
Veterans only	3	119	8.4%	0	0%	ARCHES Lodge · Gale's Lodge · VETCare Veterans Home
Youth (ages 11–17)	2	20	1.4%	0	0%	David's House · Taylor's House
Young adult only (ages 18-24)	2	16	1.1%	19	8.3%	Young Adult Shelter Community · HOST
Total	**38**	**1,421**	**100%**	**230**	**100%**	

Notes. *Population designations reflect "primary population" served. Some programs reported serving multiple populations, in which case a primary population was designated based on definitions provided earlier in this report. Beds = non-inclement individual sleeping spaces. HH = household units (1 HH ≠ 1 bed). Sequoia Crossings, Redwood Crossings and Yaquina Hall and Coral Women's House are PSH. No inclement weather or warming beds included. Day centers and warming-only programs are excluded because they carry no year-round beds, which brings 44 down to 38.*

KEY TAKEAWAYS

Section 1: Assessing the scale and capacity of shelters in Marion and Polk Counties

1. Capacity looks adequate on paper, but that is misleading.

On a typical night the system covers about **99%** of the **2,135** people identified in the 2025 Point-in-Time Count, yet that headline ignores eligibility rules, geographic access, waitlists, and a count that itself undercounts. Raw bed totals overstate how ready the system really is.

2. A handful of organizations carry the whole system.

The region's **44 programs** are run by just **18 organizations**, and a few operate most of them (MWVCAA alone runs **30%** of all programs). That concentration is a strength today and a risk if any major provider scales back.

3. The system cannot yet measure its own reach.

Only **28 of 44** programs report the unique individuals they serve and only **31** use the shared HMIS database, so the region has no accurate, unduplicated answer to how many people it shelters each year.

4. Shelters are full.

28 of 44 programs keep waitlists and most run at or near capacity. Because long-term options rarely open up, people stay longer in emergency and low-barrier beds, and the system's front door stays blocked.

5. The transitional middle is the bottleneck.

Capacity is strongest at the two ends of the continuum (emergency/crisis and permanent supportive housing) and thinnest in the transitional and bridge housing that moves people toward stability. Only one dedicated low-barrier transitional option exists (Lupe's House, 9 beds).

6. The gaps fall hardest on the most vulnerable.

Against the 2025 Point-in-Time Count, survivors of domestic violence (**130** beds vs. **420** counted), young adults (**38** vs. **88**), and youth face the steepest dedicated capacity gaps, while veterans and adults with children come closest to matching need.

Section 2: Exploring the geographic distribution of sheltering services

The geographic findings point in one direction: this is a Salem system more than a regional one. Salem holds roughly two-thirds of the region's programs and most of its beds. Polk County has eight dedicated programs, about 4.4% of estimated bed and household capacity, clustered in Dallas and Monmouth. The rural reaches of Marion County are anchored by service-rich programs like Sheltering Silverton and Salem providers who reach into these areas. For specialized populations the gap is sharpest, since youth, domestic violence, and gender-specific options are almost entirely Salem-based.

FINDING 8: Shelters are geographically concentrated in Salem, with several shelters operating regionally.

Only eight programs are specifically located in **Polk County**, together offering 84 individual beds and 3 household units. That's roughly 4.4% of the region's non-inclement weather bed and household capacity. These eight programs span a strong range of types: low-barrier and emergency sheltering at Monmouth Adult Shelter, Family Site Dallas House and Family Promise of the Mid-Willamette Valley, transitional housing at Ediger Hall and Gale's Lodge, domestic violence sheltering at Sable House, and David's House serving youth. There are also at least 20 seasonal warming beds through the Polk County Warming Centers. Four of the eight programs are in Dallas (Sable House, Gale's Lodge, Ediger Hall, and Family Site Dallas House) and three are in Monmouth (Monmouth Adult Shelter, David's House, and the Polk County Warming Centers), which leaves Independence, Falls City, and the rural western part of the county without any dedicated program of their own.

Polk County Family and Community Outreach conducted a separate count of rural Polk County in January 2025, on the same night as the Point-In-Time count, covering the area west of Highway 51.[8] That count identified 308 individuals experiencing homelessness or at risk of homelessness, including 135 unsheltered, 81 sheltered, and 92 at risk. People counted as experiencing homelessness or at risk of homelessness are unevenly distributed across Polk County. Dallas recorded 96 individuals, Monmouth 75, the Grand Ronde area 62, Independence 45, Falls City 24, and Willamina 6. Shelter capacity does not follow that distribution. Independence, Falls City, and Willamina together recorded 75 individuals and reported zero sheltered on the night of the count. Dallas and the Grand Ronde area together accounted for 76 of the 81 sheltered individuals in rural Polk County. The Polk County unsheltered count has risen in each of the last four counts. Polk County Family and Community Outreach recorded 5 unsheltered individuals in 2021, 25 in 2022, 91 in 2023, and 135 in 2025.[8]

Findings of a similar magnitude were also captured in a study conducted by Portland State University Homeless Research and Action Collaborative.[9] The Portland State University

[8] Polk County Family and Community Outreach, "Rural Polk County 2025 Point in Time Count Data," Polk County, Oregon, count conducted January 22, 2025, https://www.polkcountyor.gov/1162/Point-In-Time-PIT-Count
[9] Minji Cho, Jacen Greene, Franklin Holcomb Spurbeck, and Marisa Zapata, *2025 Oregon Statewide Homelessness Estimates* (Portland State University Homelessness Research & Action Collaborative, 2026), Table 17.

statewide estimates describe the same disparity in different terms. Using Housing Inventory Count data from the same night as the Point-in-Time count data, Polk County reported 79 total shelter beds against 357 people counted as experiencing homelessness or 22% coverage. Polk County also has a high share of its counted population living unsheltered. 65.5 percent of people counted in Polk County were unsheltered, compared with 41.4% in Marion County and 60.9% statewide.[10]

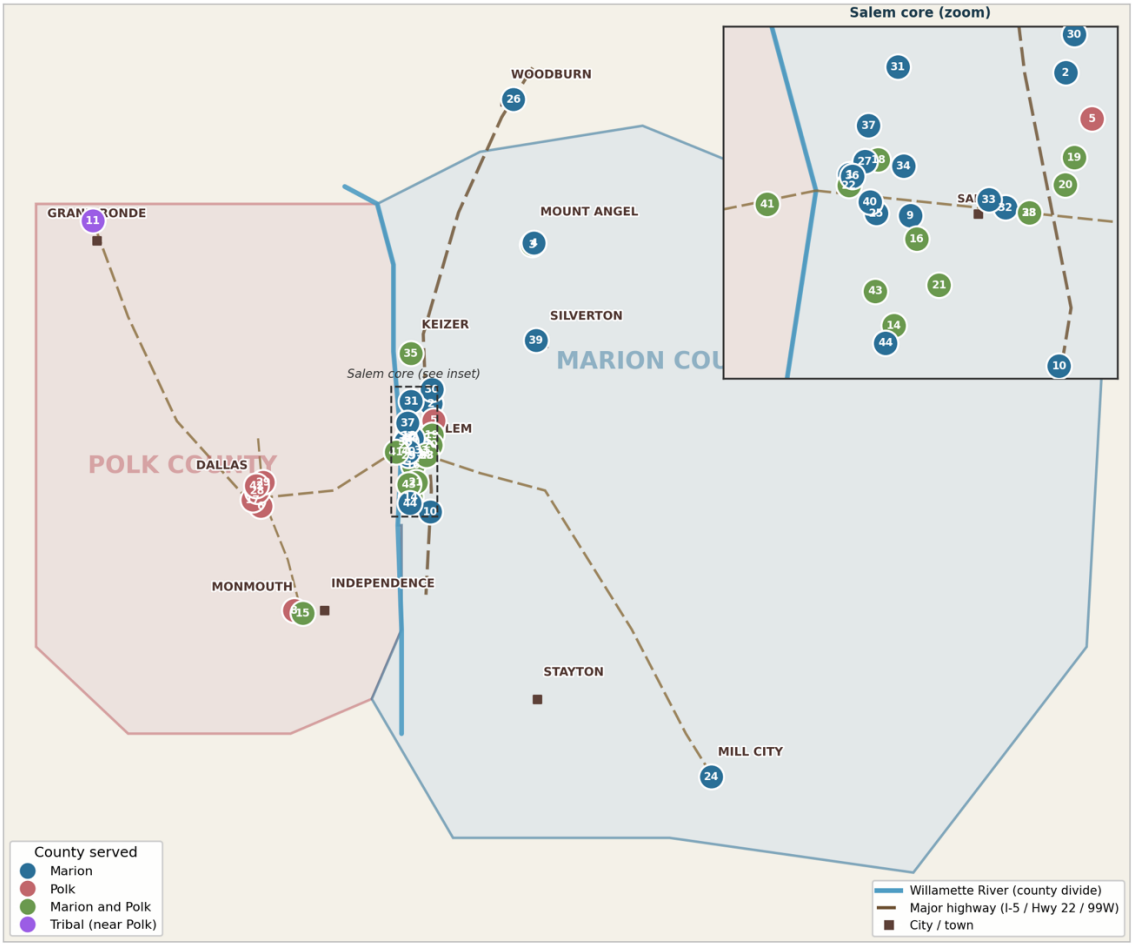
In **rural Marion County,** Mount Angel hosts two transitional programs for families, St. Joseph Family Shelter and The Father Taaffe Homes. Silverton has Sheltering Silverton (22 beds), Woodburn has ARCHES Woodburn (20 beds), and Mill City has a seasonal ARCHES warming site. Keizer, adjacent to Salem, hosts the 80-bed Simonka Place. Beyond these, the system's large-capacity resources, the ARCHES low-barrier network, the region's biggest congregate shelters, bilingual staffing, behavioral health services, and around-the-clock access, are overwhelmingly located in Salem itself. Again, Point-In-Time Counts do not give us an accurate picture of shelter needs in rural Marion County alone.

The remainder of programs are based in **central Salem**. At least a dozen of these programs located in Salem indicated that they do serve both Marion and Polk County residents. This includes programs like Center for Hope and Safety, which provide short-term hotel stays for people in both counties. Still, someone experiencing homelessness in rural Polk County or the eastern and northern reaches of Marion County may have to travel to Salem or reach a Salem-based provider to get support.

[10] Minji Cho, Jacen Greene, Franklin Holcomb Spurbeck, and Marisa Zapata, *2025 Oregon Statewide Homelessness Estimates* (Portland State University Homelessness Research & Action Collaborative, January 2026), Tables 1 and 2.

Figure 8

Shelters by geographic location



FINDING 9: Programs located in Polk County offer somewhat more limited access.

While Polk County programs span shelter types, eligibility and service access is more limited. Ediger Hall requires that families be from Polk County and have their next housing step arranged, so it functions as a bridge for households on their way out rather than a door for those in crisis. Sable House is the county's only domestic violence shelter (though Center for Hope and Safety operates regionally) and the Polk County Warming Centers operate only from 7pm to 7am during inclement weather at rotating sites. Finally, there are no day or resource centers located anywhere in Polk County. The region's day centers, including the ARCHES Day Center and ARCHES Family First, are in Salem and open to people from across both counties, but

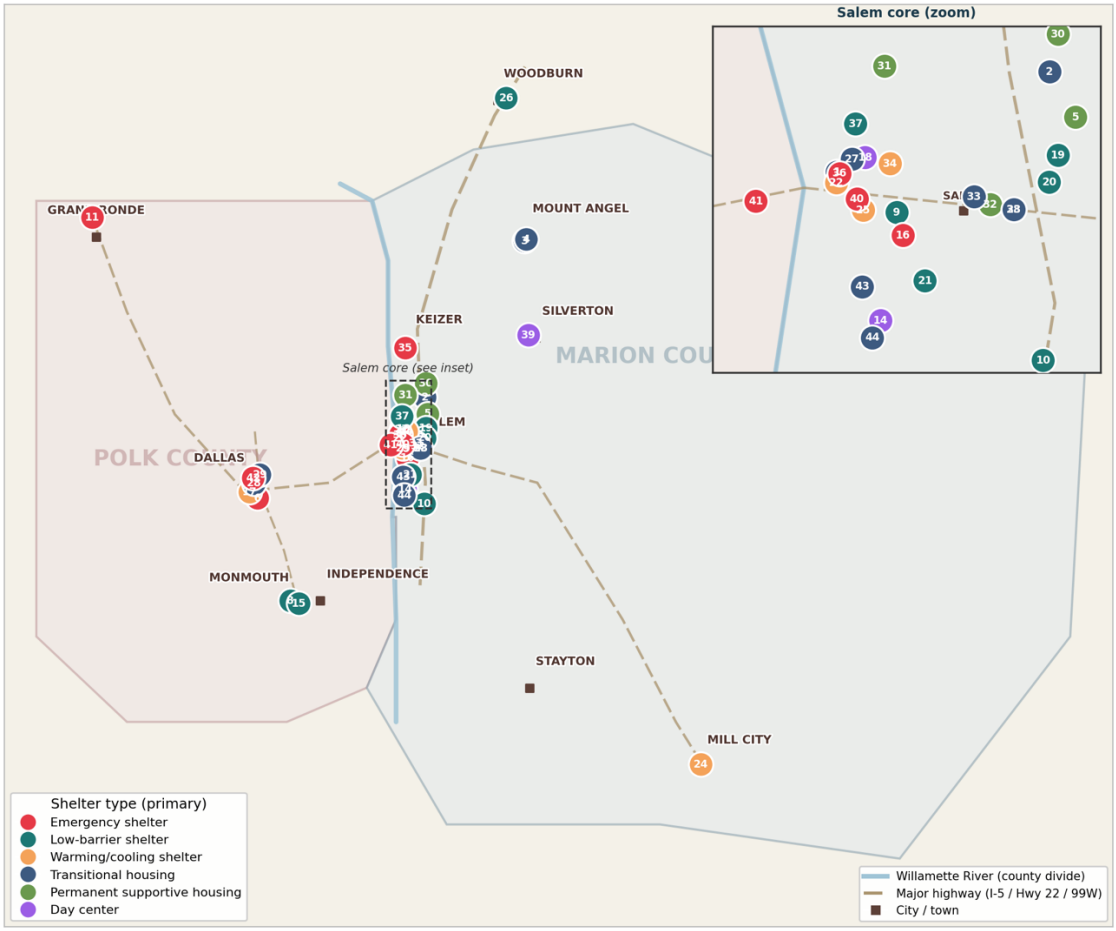
reaching them requires traveling to Salem, the same barrier that shapes access to the rest of the system.

How people access shelter in Polk County is a potential barrier, as most of Polk's capacity is not walk-in. The Church at the Park programs (Monmouth Adult Shelter and Family Site Dallas House) are entered through an online application, which assumes internet access, Family Promise has a waitlist by default, and Gale's Lodge and Ediger Hall are referral-only. The seasonal warming centers are the main walk-in option, and they note that transportation within rural Polk County can be arranged through the Cherriots system.

Service depth and funding in Polk County are uneven. Several Polk County programs provide genuine wraparound services such as housing navigation, case management, and recovery support. Funding tends to be thin and single-source, generally state dollars (Monmouth Adult Shelter, Family Site Dallas House) or private funding (Ediger Hall), which leaves these programs exposed to a change in any one funder. Sable House and Family Promise are the exception, drawing on a mix of sources. Two of the eight programs are operated by Church at the Park, a Salem-based organization.

Figure 9.1

Geographic Distribution by Shelter Type



The map shows the system's geography at a glance. Sheltering programs are so densely concentrated in Salem that the city must be broken out into a separate zoomed inset to be legible at all, while the rest of the two-county region reads as a thin scattering of single dots. Salem holds roughly two-thirds of the region's programs and most of its beds, and it is the only place where the full continuum of shelter types appears together. Emergency, low-barrier, warming, transitional, Permanent Supportive Housing, and day-center programs all sit within a few square miles of one another there.

Polk County's capacity clusters in Dallas and Monmouth, with a tribal program near Grand Ronde, and the outer towns of Marion County, Woodburn, Mount Angel, Silverton, and Mill City, carry only a program or two apiece, often of a single type such as a warming site or a small transitional home. A person experiencing homelessness in one of these communities may find one kind of help nearby but must travel to Salem for almost everything else, and those distances, paired with limited transit, turn geography itself into a barrier to access.

FINDING 10: Dedicated providers for specialized populations are thin in rural Marion County.

The geographic gap appears sharpest for populations that depend on specialized, often single-site programs like youth and survivors of domestic violence. For these groups there are only one or two providers in the entire region, and they sit in Salem, so a person living in the rural parts of Marion County, in Santiam Canyon communities like Mill City, or in Woodburn, Silverton, Mount Angel, or Stayton, has no dedicated nearby option at all. That said, Sheltering Silverton does report offering a robust set of services across populations, including gender-inclusive services and services for families and people with disabilities.

Youth options provide the clearest example. The region's only residential youth shelters are Taylor's House in Salem and David's House in Monmouth, with the Next Steps Youth Day Center in Salem offering daytime services but no beds. None of the three is in rural Marion County, so an unaccompanied minor in Stayton or the Santiam Canyon would have to reach Salem (around 45 minutes away by car from the canyon and considerably longer by the limited transit that exists) to find a dedicated youth bed. For a minor without a vehicle or a trusted adult to drive them, that distance can be the difference between being sheltered and sleeping outside.

Survivors of domestic violence face the same problem, compounded by safety. The region has only two domestic violence shelters, Center for Hope and Safety in Salem and Sable House in Dallas, and neither is in rural Marion County. However, Center for Hope and Safety does provide services across the state, including emergency hotel shelter in a confidential location. Outside of that, a survivor in eastern or northern Marion who is fleeing violence must travel to Salem or across the river into Polk County, with no intermediate or local option, at exactly the moment when leaving one's own community, arranging transportation, and protecting a confidential location are most difficult.

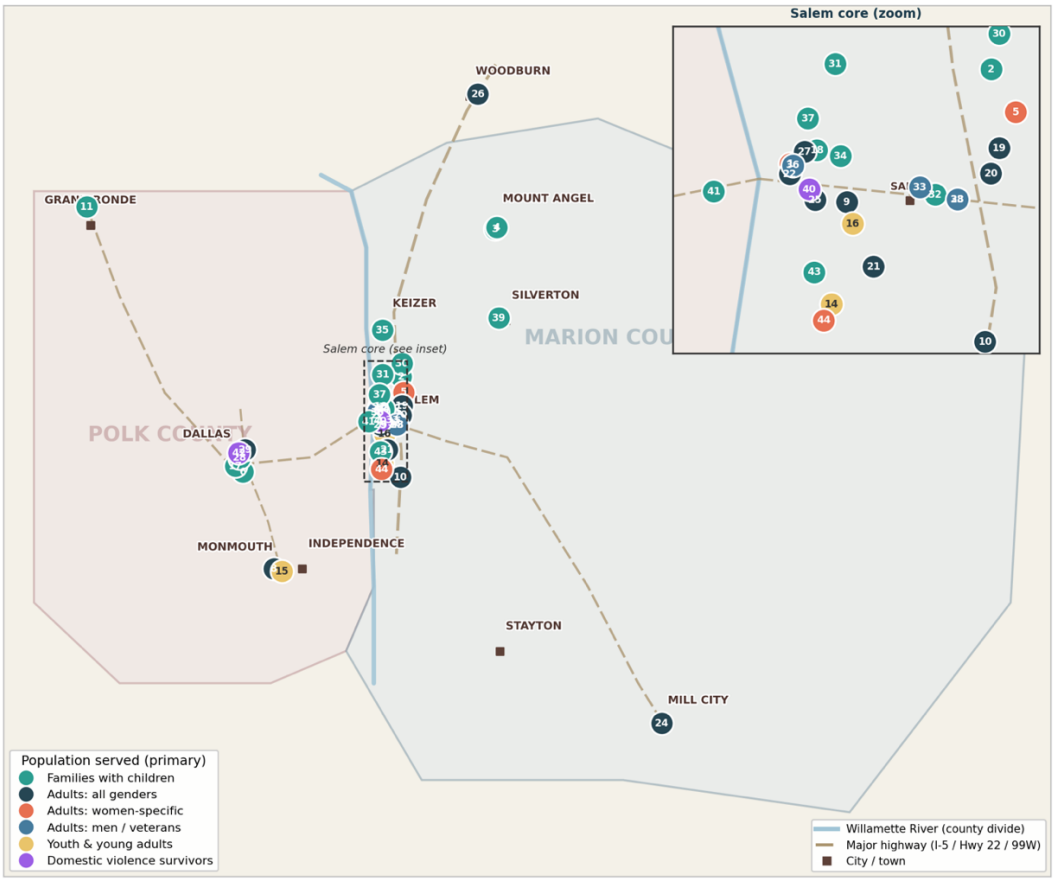
Men in rural areas have no gender-specific shelter within reach. All three men-only programs, Men's Mission, CRAWL, and the VETCare Veterans Home, are in Salem. A man experiencing homelessness in rural Marion who needs or prefers a men's program has no closer option**.** There is, however, low-barrier shelter capacity serving all genders in Woodburn and Silverton, as well as a warming-only site in Mill City. While Point-In-Time Counts indicate more men experience homelessness than women, more investigation is required to understand whether men’s only services are preferred or needed.

Families have a few more shelter options outside Salem than the other groups. The options tend to be transitional rather than emergency. Mount Angel has two transitional programs for families (St. Joseph Family Shelter and The Father Taaffe Homes) and Sheltering Silverton offers emergency shelter to families for 30 days at a time. Keizer, just north of Salem, has the 80-bed Simonka Place. Family Promise in Polk County also offers substantial emergency beds for families.

Without more detailed geographic breakdown of Point-In-Time Counts, it's unclear whether there is, in fact, a gap of beds or services in rural Marion County. What we can say is that for, youth, survivors of domestic violence, and men seeking gender-specific shelter, the rural parts of the county effectively have no dedicated provider, and reaching the nearest one means a trip to Salem.

Figure 10

Geographic Distribution by Population Served



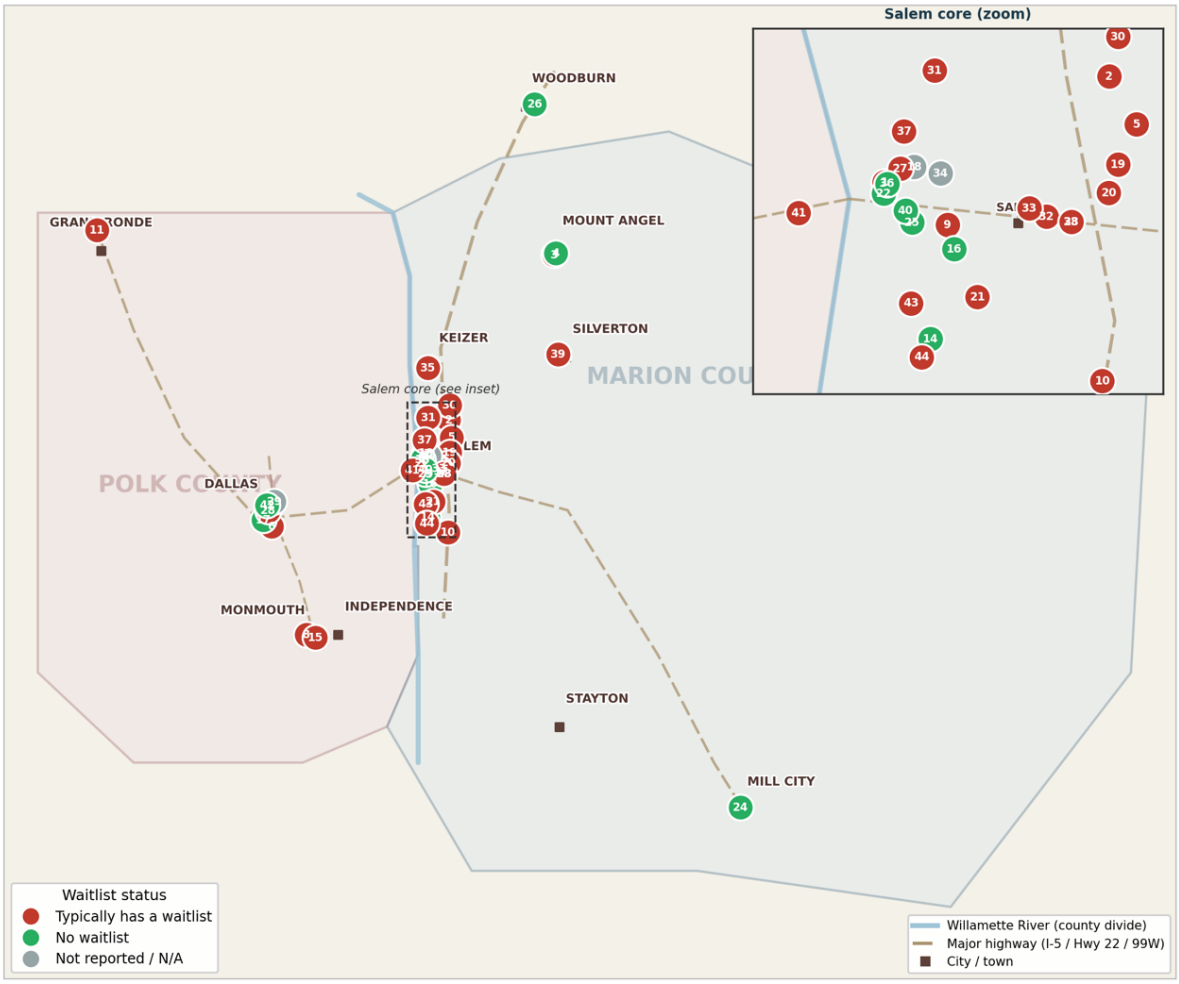
This map displays the shelters by the type of population it serves. Like other maps, the dots are concentrated in Salem. The rural towns carry a thin and uneven scattering. A youth or young-adult program (gold) appears in Monmouth, family programs (teal) turn up in Mount Angel and Silverton, and a domestic violence program (purple) sits in Dallas, but no single community outside Salem offers more than a couple of population types. The pattern shows how thin the options become for any specialized group once you leave the city, since a person seeking youth, domestic violence, or gender-specific shelter almost likely must go to Salem to find it.

FINDING 11: Wait lists are common across the two-county region.

The map below shows programs by whether they typically operate a waitlist. Across both counties, most shelters report operating at or near capacity with a waitlist, including nearly every program in the dense Salem core. The green dots, programs with no waitlist, are scattered and few, and they tend to be warming sites, day centers, or single-population programs rather than general, year-round shelter. The pattern reinforces what the bed counts already suggest: open capacity is rare almost everywhere in the system, so on a typical night a person looking for a bed faces a waitlist regardless of where in the region they are.

Figure 11

Geographic Distribution of Programs with and without Waitlists



For example, in Polk County, the single program that runs without a waitlist year-round is Sable House, which fills its 10 beds first come, first served based on safety need. However, those beds are reserved for survivors of domestic violence and sexual assault. The two other programs that report no waitlist do not fill the gap: the Polk County Warming Centers take walk-ins but open only overnight during inclement weather, and Gale's Lodge shows no formal waitlist only because its five transitional beds are filled by referral and turn over every couple of years. The result is that a person in Polk County who is not fleeing domestic violence, and who is not already on a referral pathway, has essentially no year-round bed available without joining a waitlist.

KEY TAKEAWAYS

Section 2: Exploring the geographic distribution of sheltering services

1. This is a Salem concentrated system.

Salem holds roughly **two-thirds** of the region's programs and most of its beds, and it is the only place where the full continuum of shelter types (emergency, low-barrier, warming, transitional, Permanent Supportive Housing, and day centers) sits together.

2. Polk County is thinly served and unevenly covered.

Just **8 dedicated programs** (about **4.4%** of bed and household capacity) cluster in Dallas and Monmouth, leaving Independence, Falls City, and the rural western county with no dedicated program of their own.

3. Rural Marion County relies on a scattering of single-type programs.

Towns like Woodburn, Silverton, Mount Angel, and Mill City carry only a program or two apiece, often of one type, while the system's large-capacity resources (the ARCHES low-barrier network, bilingual staffing, behavioral health services, and 24/7 access) are overwhelmingly in Salem.

4. Specialized populations have almost no rural option.

Youth, domestic violence, and gender-specific programs are nearly all Salem-based, so a young person or survivor in rural Marion County must travel to Salem (up to about **45 minutes** from the Santiam Canyon by car, and longer by limited transit) to reach dedicated help.

5. Getting in the door is harder outside Salem.

Most of Polk County's capacity is not walk-in (online applications, referral-only access, and default waitlists), there are **no day or resource centers** anywhere in Polk County, and several programs depend on thin, single-source funding.

6. A waitlist is the norm almost everywhere.

Most shelters across both counties run at or near capacity with a waitlist, and the few programs without one tend to be warming sites, day centers, or single-population programs, so a person seeking a year-round bed faces a waitlist regardless of where in the region they are.

Section 3: Approaches and requirements for accessing and gaining entry to services.

How people get into shelter matters as much as how many beds exist. This section turns from counting capacity to examining the doors into it. The picture that emerges is that physical availability and actual accessibility are not the same thing. Most beds are open around the clock, yet the pathways to reach them, intake schedules, online applications, referrals, and Coordinated Entry, often narrow precisely when and for whom they are needed most. The findings that follow look at operating hours, what "low barrier" does and does not guarantee, how people are admitted, and how programs communicate that they exist at all.

FINDING 12: Most shelter beds have 24/7 access, but barriers still exist for families seeking shelter outside weekday business hours.

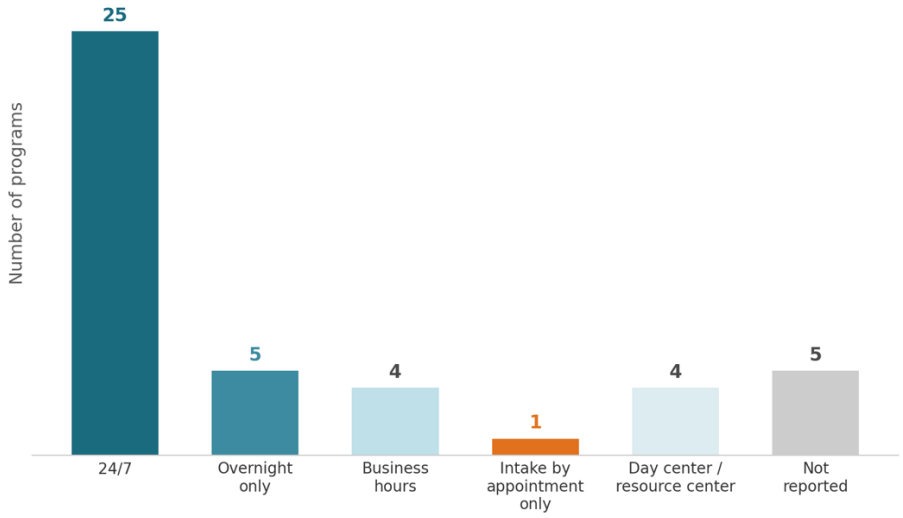
Most shelter programs (**25 of 44**) offer 24/7 access, and this coverage is most consistent where it matters most for resident safety: all four **Permanent Supportive Housing** programs and 13 of 16 programs with **low-barrier** designation (including DV programs) are available around the clock. This pattern makes sense, since these are the programs where residents live on site or arrive in acute crisis, and where a locked door overnight would carry real risk.

Families already housed in the system are similarly well-served; 12 of 20 family-serving programs operate 24/7. For families in crisis, though, intake rather than access can be the critical bottleneck. For example, Family Shelter Community (CCS), the second-largest family program by household count, requires appointment-only intake, and St. Francis Family Housing accepts new clients only during weekday business hours. A family arriving in crisis on a Friday evening therefore has limited pathways into the system until the next business day.

Five programs did not report operating hours, and several others noted different hours for shelter access versus staffed support, making it difficult to assess true around-the-clock service capacity from this data alone. As a result, the share of programs offering genuine 24/7 entry is best read as an approximation.

Figure 12

Shelter Programs by Operating Hours Reported



FINDING 13: Nearly half (47.9%) of non-inclement beds and one third (30.4%) of family units are "low barrier."

The definition of "low barrier" may vary somewhat from program to program, since programs self-identified their own shelter types rather than being classified against a single standard. In all, **16 programs identified as "low barrier,"** and many of these also identified as something else, including emergency shelter, rapid rehousing, transitional housing, day centers, and warming or cooling shelters. In practice, this means a program counted as "low barrier" may apply that approach differently, whether by reducing sobriety or identification requirements, easing entry conditions, or lowering other common barriers like justice involvement, mandatory program participation, or pet restrictions. Hence, the "low barrier" label signals a shared intent more than a uniform set of practices. This overlap is worth keeping in mind when interpreting "low barrier" counts elsewhere in this report, as the same program may appear under more than one shelter type.

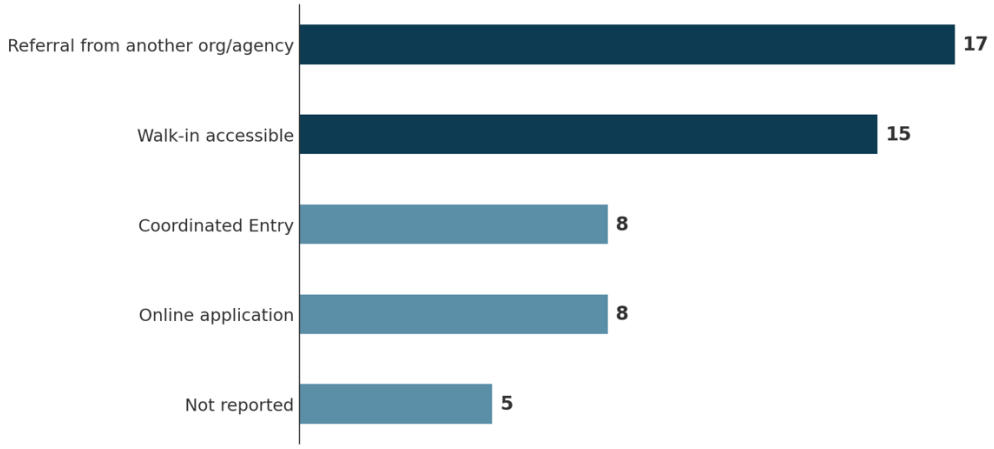
FINDING 14: How people access services tells a different story—"low-barrier" does not necessarily mean open-door access.

Fifteen of 44 programs (34%) are walk-in accessible and reachable by anyone in crisis without a phone, internet, or prior organizational relationship. An additional four programs allow for "self-referral" in some way, often by phone. The rest of the system requires either an online application (8 programs, 18%), a referral from another organization or agency (17 programs, 39%), or Coordinated Entry engagement (8 programs, 18%). Five programs (11%) did not report how people access services as a part of this landscape scan.

Entry barriers create a significant structural hurdle for people new to homelessness, distrustful of systems, or lacking digital access. Together, referral from another organization and Coordinated Entry referrals are primary access methods at 22 programs (50%). Referral-dependent access means the system is largely closed to those who haven't already been identified by another program or organization.

Figure 14

Shelter Access Methods Across Programs



Notes. *Includes 44 programs. Some programs appear in multiple categories.*

Coordinated Entry (CE) is used in some capacity at 18 programs, most of them low-barrier. Three-quarters of programs that self-identify as low-barrier mention Coordinated Entry in their services or access methods, compared to just 17% of non-low-barrier programs. CE functions less as a universal front door and more as the operating infrastructure of the low-barrier network: eight programs use it as one of their access pathways (including 3 PSH programs that use alternative CE) and 10 offer CE assessment as a service to residents. None of these groups overlap, meaning CE plays a different role depending on where in the system a person lands.

The 26 programs that did not mention Coordinated Entry fall into a few distinct categories. Two DV-specific shelters (Center for Hope and Safety and Sable House) do not participate in HMIS due to **confidentiality protections** for survivors. Three structured residential programs (St. Joseph Family Shelter, Father Taaffe Homes, and Warriors of Hope) also do not report using HMIS. For the remaining programs, it is unclear whether the absence of CE mentions reflects programs operating outside the system or simply programs that did not report their use of it.

Either way, the pattern is clear: there is no single, consistent front door into the system. Where a person enters, and whether they encounter Coordinated Entry at all, depends heavily on which program they happen to reach first and whether that program is part of the low-barrier network.

FINDING 15: Referral and outreach dominate the communication methods programs use to reach people experiencing homelessness.

The system communicates primarily through **professional networks and street outreach** rather than public-facing channels. Among the 39 programs that reported how they get the word out, the three most common methods are referral from other organizations (32 programs), street outreach (29 programs), and word of mouth (26 programs). Public, self-serve channels that a person might find on their own trail behind, with a website used by 21 programs (12 of which also use social media). In other words, the most common ways people learn about shelter all depend on already being connected, whether to another program, to an outreach worker, or to peers who have moved through the system before.

Word of mouth ranking third is especially telling, since it suggests the system leans heavily on informal peer networks to spread information. That reliance is both a strength and a vulnerability. Peer networks are trusted, low cost, and often reach people that formal channels miss, particularly those who are wary of institutions. But they reach only those who are already connected to someone in the know. A person new to homelessness, socially isolated, distrustful of others, or living far from where outreach teams concentrate may never learn that a given program exists. This is sharpest in **rural areas**, where street outreach may be less concentrated and peer networks are more dispersed.

The way programs spread the word reinforces how connection-dependent the system is. The two most common channels, **referral from other organizations and street outreach, are present at 73% and 66% of programs respectively.** Word of mouth outreach is present at 59% of programs. All three leading approaches rely on a person already being linked to an agency, an outreach worker, or a peer. Self-directed channels that someone in crisis might use on their own are a smaller share: online at 47% of programs, in-person at 45% or programs, and phone or text at just 25% of programs. In short, the system reaches people mainly through professional and informal networks rather than open, public-facing doors, which works well for those already connected but may leave the newly homeless, the isolated, and rural residents the hardest to reach.

Figure 15

Communication Methods Used by Programs



KEY TAKEAWAYS

Section 3: Approaches and requirements for accessing and gaining entry to services

1. Physical availability is not the same as real access.

Most beds are open around the clock (**25 of 44** programs offer 24/7 access), yet the pathways to reach them (intake schedules, applications, referrals, and Coordinated Entry) often narrow precisely when and for whom they are needed most.

2. Families in crisis can hit an intake wall after hours.

24/7 access is strongest where safety demands it (all four PSH programs and 13 of 16 low-barrier programs), but intake, not access, is the bottleneck for families. Appointment-only or weekday-business-hours intake (for example, Family Shelter Community and St. Francis Family Housing) can leave a family arriving on a Friday evening with no way in until the next business day.

3. "Low barrier" signals intent but not a uniform standard.

Nearly half of non-inclement beds (**47.9%**) and about a third of family units (**30.4%**) are low-barrier, but 16 programs self-identified the label and apply it differently, so it reflects shared intent more than a consistent set of practices.

4. There is no single front door, and half the system is referral-gated.

Only **15 of 44** programs (34%) are true walk-in access. Half (**22 programs**) are reached only through referral or Coordinated Entry, so the system is largely closed to anyone not already identified by another program. Where a person enters depends on which program they happen to reach first.

5. The system reaches people through networks, not open public doors.

Programs get the word out mainly through referrals (32 programs), street outreach (29), and word of mouth (26), while self-serve channels lag (a website at just 21). All three leading methods depend on already being connected, which leaves the newly homeless, the socially isolated, and rural residents the hardest to reach.

Section 4: Examining the accommodations provided to service diverse population.

Having mapped where shelter exists and how people get in, this section turns to who the system is built to serve, and how well its capacity matches the diversity of the people experiencing homelessness in the region. The findings look across gender, race and ethnicity, language, sexual orientation and gender identity, special populations, and physical accessibility. A consistent theme runs through them: the system is broadly open in principle, with most capacity available to all genders, all races and ethnicities, and a wide range of needs, but that openness is not the same as being equipped to serve specific communities well. Where the data allows, it reveals real strengths, such as substantial Spanish-language capacity and a developed continuum for veterans. Where it does not, it points to the limits of a landscape scan, which can document what programs say they offer but not the demographic reality of who walks through the door.

FINDING 16: Shelter capacity is largely gender inclusive or not serving a specific gender.

Most shelter capacity across Marion and Polk Counties, **66% of beds and 94% of family units, serves all gender identities.** This reflects a system oriented toward access regardless of gender, and it is especially pronounced for families, where nearly all household capacity is open to any family. For transgender and non-binary individuals this matters. While many programs are open to serving them, there are no programs exclusively tailored to them.

Men-only capacity is substantial but heavily concentrated. Three programs serve men only, accounting for 310 beds, or 22% of total individual bed capacity, but 248 of those 310 beds (80%) are at Men's Mission alone, with the rest split between CRAWL (32 beds) and the VETCare Veterans Home (30 beds). Men's gender-specific capacity therefore rests almost entirely on a single program. All three men-only programs are in Salem, so men seeking gender-specific shelter anywhere else in the region must travel into the city.

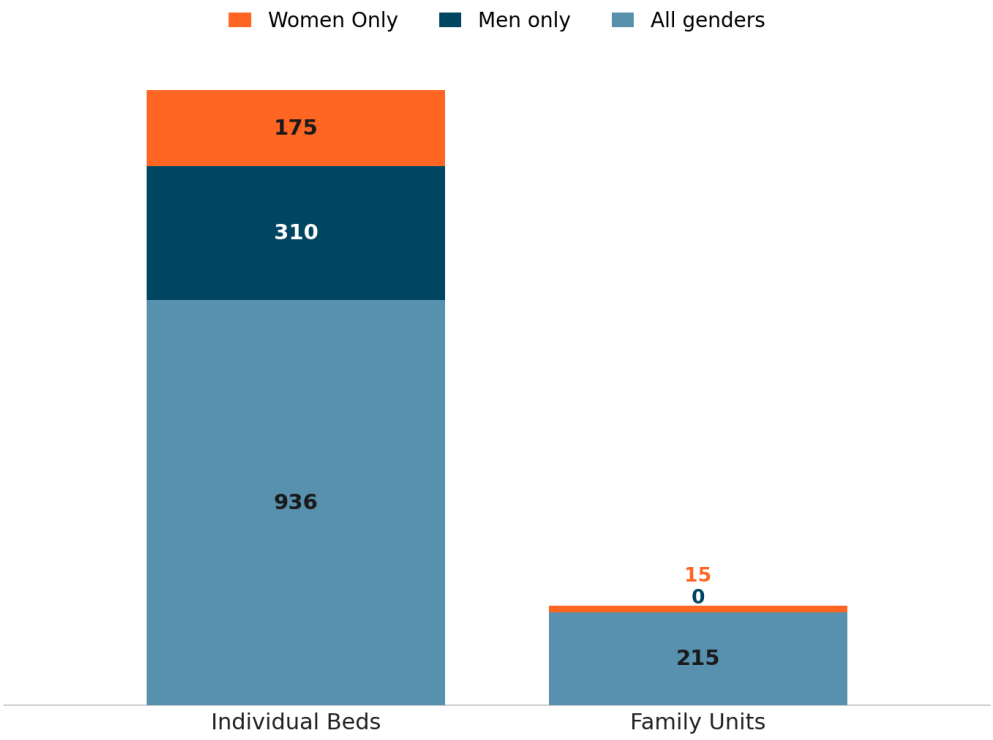
Women-only capacity is thinner overall but more distributed, both by program type and by geography. Six programs serve women only, totaling 175 beds (12%) and 15 household units, and they span a meaningful mix of models: emergency and low-barrier sheltering at SafeSleep United, transitional housing at Women at the Well Grace House, Simonka Place, and The Father Taaffe Homes, recovery-focused housing at Lupe's House, and Permanent Supportive Housing at Coral Women's House. Simonka Place (80 beds) anchors women's capacity much as Men's Mission anchors men's. Unlike men's capacity, though, women's gender-specific options extend beyond Salem, with Simonka Place in Keizer, and The Father Taaffe Homes in Mount Angel.

The **concentration of gender-specific programs in and around Salem** means that men and women seeking gender-specific shelter in rural Polk County or the outer reaches of Marion County have limited local options. They must either travel to Salem or enter the all-genders

system, which, while it accounts for most of the region's capacity, may not feel safe or appropriate to everyone, particularly survivors of gender-based violence.

Figure 16

Bed and Family Unit Capacity by Gender



FINDING 17: More information is needed about how culturally specific communities among the unhoused are served across the shelter continuum.

From the 2025 Point-In-Time Count data, we know that Latino (93 total) and Indigenous (35 total) neighbors are disproportionately unsheltered in the region. Those who identify as multi-racial (81 total), Native Hawaiian or Pacific Islander (53 total) and Black (43 total), are also overrepresented. The 2026 Point-In-Time Count confirms that these populations continue to be sheltered in the region.[11]

Of the 44 programs, 41 reported that they serve all races and ethnicities. This likely reflects a general openness rather than targeted outreach or **specialized cultural capacity**, and the two are worth distinguishing. Serving everyone is not the same as being equipped to serve a particular community well. More information would be needed to determine how, or whether, culturally specific practices are implemented within these programs. Only four programs are culturally specific, three serving tribal members through the Confederated Tribes of Grand Ronde (Warriors of Hope, Village One, and Village Two), and only one, CRAWL, lists Black or African American individuals as a primary population served. No program indicates that it

[11] Mid-Willamette Valley Homeless Alliance. (2026). *PIT summary report: OR-504 Salem/Marion, Polk Counties CoC* [Sheltered-only Point-in-Time count conducted January 28, 2026]. https://mwvhomelessalliance.org/wp-content/uploads/2026/06/PIT_Summary_Report_2026.pdf

focuses on serving the mid-Willamette Valley's significant Latino community, even though much of the system offers some Spanish-language access.

Language capacity tells a similar story of broad but uneven reach. Spanish is reasonably well covered: about 24 programs (55%) report bilingual Spanish staff or advocates, and as many as 33 (75%) offer Spanish in some form. Beyond Spanish, coverage thins sharply. Only four programs report Russian-language capacity, despite the sizable Russian-speaking population concentrated around Woodburn, two report Marshallese, one reports Vietnamese and Chinese, and three offer sign language. Chuukese, a key language among Pacific Islanders, does not appear at any program, and phone-based interpretation through a language line is available at only three. For families and individuals whose first language is not English or Spanish, the system offers very few points of entry, and language access on its own does not amount to culturally responsive care.

The inventory does not capture the demographic composition of the people each program shelters, so it cannot show whether the system's stated openness translates into proportionate access for communities of color, immigrants, and refugees, or whether groups are underrepresented relative to their presence in the unhoused population. A dedicated follow-up data collection effort, paired with HMIS-linked demographic reporting, would be necessary to characterize accurately how the shelter system is reaching, or failing to reach, these communities.

FINDING 18: No dedicated LGBTQIA+ sheltering exists in the region, and inclusive practice is largely undocumented.

Across all 44 programs, not one is designated to serve LGBTQIA+ individuals, and only one program (St. Francis Family Housing) names this population among those it serves. On the question of gender inclusion specifically, only SafeSleep United Women’s Shelter explicitly lists transgender and non-binary individuals in its gender criteria. As noted in *Finding 16*, no program is explicitly designated for transgender or non-binary residents, though providers like Sheltering Silverton report serving them. The remaining programs either serve all genders by default or use binary, gender-specific criteria. While “all genders” suggests openness, gender-segregated intake can create friction for transgender and non-binary people seeking shelter, and the data does not tell us how individual programs handle placement, pronouns, or safety for these residents in practice. For example, it is unclear how a transgender man might be received and served at a men’s only shelter. This is an area where the landscape scan can identify the structural absence but cannot characterize lived experience.

FINDING 19: Veterans have the most developed support across the shelter continuum. Other special populations are more concentrated in crisis support.

For nearly every special population, including survivors of domestic violence, veterans, seniors, people with behavioral health needs, people who are justice-involved, and people with disabilities, dedicated programs are scarce, and these groups are served mainly as secondary

populations within general programs rather than through a tailored pathway. The system tends to recognize them at the crisis point, but there is almost no population-specific route beyond emergency shelter for most of them. Veterans are the clear exception, with the most developed cross-continuum support of any group: dedicated programs at the low-barrier levels (ARCHES Lodge) and transitional (VETCare, Gale's Lodge), in addition to being served at several emergency programs. Most other programs are general-population programs. Reentry and justice-involved services are nearly absent, and only a handful of programs serve people who are justice-involved, none as a dedicated focus. For a group with significant and often prolonged housing instability, this is a notable gap.

FINDING 20: English and Spanish are the primary languages offered across programs.

The system has meaningful **Spanish-language capacity**. About 55% of programs offer bilingual staff and another 20% provide some form of interpretation, so roughly three-quarters of programs can serve Spanish-speaking clients in some way. The quality of that "interpretation" varies widely, however, ranging from trained bilingual case managers and formal phone-based services like Language Line to informal, on-the-spot tools. At least one program reported relying on Google Translate in the absence of bilingual staff, and others described arranging interpretation only as needed. As such, a Spanish speaker's actual experience might depend heavily on which program, and even which shift, they reach. Only about three programs report access to a formal language line, which means much of the interpretation in the system is ad hoc rather than professionally provided.

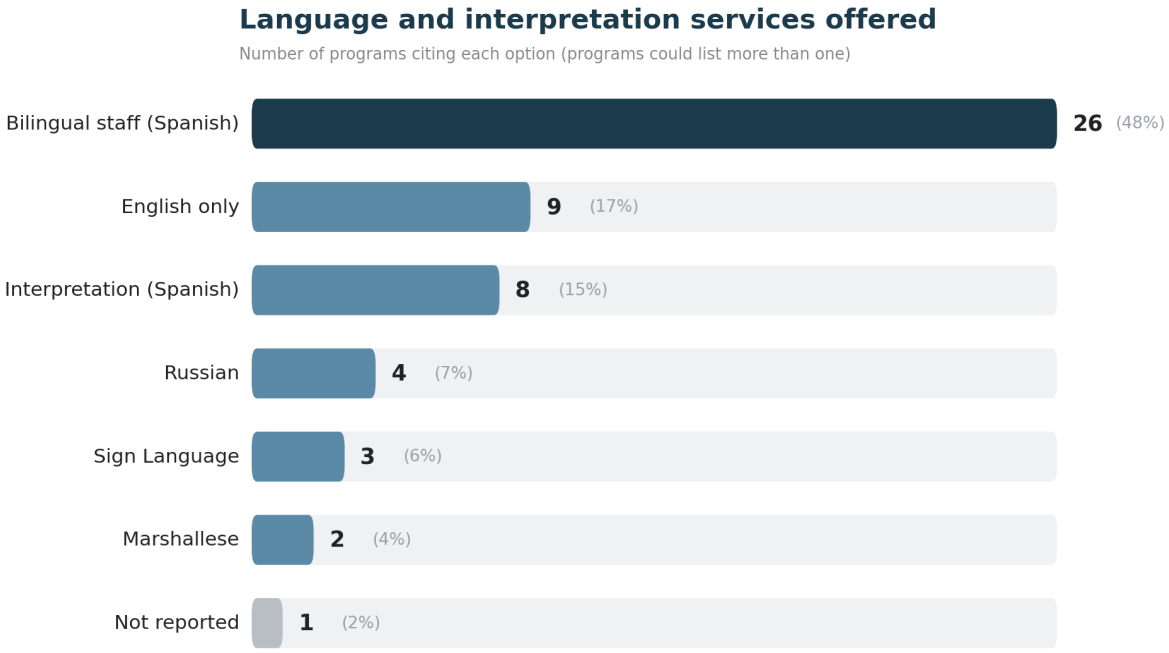
Beyond Spanish, **language access drops off sharply for common languages**[12] in Marion and Polk counties. Russian is available at only four programs (Redwood Crossings, Sequoia Crossings, Yaquina Hall, and Family Promise); sign language at three (Sable House, Sheltering Silverton, and Family Promise); Marshallese at two (Family Shelter Community and Family Promise); and Chinese and Vietnamese at Faily Promise only. This matters because several of these languages correspond to established communities in the region, including the Russian-speaking population concentrated around Woodburn and Marshallese and Chuukese[13] speakers among Pacific Islander residents. For someone whose primary language is neither English nor Spanish, the system offers very few reliable points of entry.

[12] American Community Survey estimated number of limited English proficient (LEP) individuals five years and older who self-evaluate their ability to speak English as “less than very well.” Data analysis by the Population Research Center at Portland State University (2024). https://sos.oregon.gov/elections/tac/pages/common-language-county.aspx

[13] While the ACS data above does not capture Chuukese speakers at the county level, the Portland-Salem corridor is home to one of the largest Micronesian communities in the country, including Chuukese.

Figure 20

Share of Programs Offering Language Services



FINDING 21: Physical accessibility for people with disabilities is affirmed at only a minority of programs and goes largely unreported.

Of the 44 programs inventoried, only **12 (27%)** reported any information about ADA or physical accessibility. Among those that did, all described themselves as at least partially accessible, but several qualified that accessibility is limited to one suite, a single downstairs room, first-floor units, or a day center rather than the sleeping areas (The Father Taaffe Homes, Simonka Place, Sable House, St. Francis Family Housing, Family Promise). The other **32 programs did not report accessibility status at all**, which means the system cannot currently say how many beds are usable by people with mobility disabilities. This gap compounds the privacy and congregate-setting barriers described in *Finding 25*, since congregate and bunk-bed environments are often the least accessible. Separately, eight programs identify people with disabilities or in behavioral health crisis among the populations they serve, but consistent with *Finding 19*, that capacity sits almost entirely at the emergency and crisis level rather than across the housing continuum. Standardized accessibility reporting would be a meaningful next step toward understanding whether the system can serve residents with disabilities.

FINDING 22: Faith-based organizations operate a substantial share of the system's beds, concentrated in its largest and highest-barrier congregate programs.

Twelve of 44 programs (27%) are faith-affiliated, together accounting for roughly **496 individual beds and 91 household units**. These divide into two groups. Six programs operated by Church at the Park describe themselves as faith-inspired but report that faith is not a condition of receiving services. The other six are more traditionally faith-based: two Catholic Community Services programs (St. Joseph Family Shelter, The Father Taaffe Homes), two Union Gospel Mission programs (Men's Mission, Simonka Place), Seed of Faith Ministries' CRAWL, and Women at the Well Grace House. The concentration matters because the system's two largest congregate adult shelters, **Men's Mission (248 beds)** and **Simonka Place (80 beds)**, are both faith-based, both single-gender, and both fall in the abstinence-plus-drug-testing category identified in *Finding 23*. For an adult seeking one of the region's largest pools of congregate beds, a faith-based environment and the highest-barrier substance-use policy often travel together. The landscape scan does not capture whether religious programming is required, encouraged, or simply present, so it cannot determine the degree to which faith creates an access barrier. It does appear, however, that the strictest pre-entry requirements have lower waitlist rates than behavioral-model programs — which would support the hypothesis that higher barriers reduce demand. Either way, faith-based organizations are central to the region's congregate capacity, which is reason enough to examine the question directly in the future.

KEY TAKEAWAYS

Section 4: Examining the accommodations provided to serve diverse populations

1. Open in principle is not the same as equipped in practice.

Most capacity serves all genders (**66%** of beds and **94%** of family units) and **41 of 44** programs serve all races and ethnicities, but that breadth reflects general openness rather than targeted capacity to serve specific communities well.

2. Gender-specific shelter is concentrated and Salem-centric.

Men-only capacity (310 beds) rests almost entirely on one program (Men's Mission holds **80%**), women-only capacity is thinner (175 beds) but more distributed, and all three men-only programs are in Salem, so anyone seeking gender-specific shelter outside the city has few local options. No program is dedicated to transgender or non-binary residents.

3. Culturally specific capacity and non-Spanish language access are thin.

Only **four programs** are culturally specific (three tribal, one Black-serving), none focus on the region's large Latino community, and while Spanish reaches roughly **75%** of programs, coverage for Russian, Marshallese, Chuukese, and other established community languages is minimal.

4. Spanish access is broad but uneven in quality.

About **55%** of programs have bilingual staff, yet interpretation ranges from trained case managers and formal phone lines (only about 3 programs) to informal tools, with at least one program relying on Google Translate, so a Spanish speaker's experience can depend on which program, or even which shift, they reach.

5. Only veterans have a full continuum; most special populations are met only at crisis.

Veterans have dedicated low-barrier and transitional programs, but survivors, seniors, justice-involved people, and those with disabilities or behavioral health needs are served mostly as secondary populations at the emergency level. Reentry services are nearly absent, and no dedicated LGBTQIA+ shelter exists anywhere in the region.

6. Accessibility is largely unreported, and the biggest congregate beds carry the highest barriers.

Only **12 of 44** programs (27%) reported any ADA or physical accessibility, so the system cannot say how many beds are usable by people with mobility disabilities. The two largest congregate shelters (Men's Mission and Simonka Place) are both faith-based, single-gender, and highest-barrier on substance use.

Section 5: Shelter Environment and Policies

The previous sections counted beds and mapped how people reach them. This section looks at what those beds are actually like to stay in, the services attached to them, the privacy of the sleeping arrangements, the substance-use rules that govern entry, and whether a person can bring a pet. These environmental and policy features determine whether a bed that exists on paper is one a given person can genuinely use. A recurring theme runs through the findings: the system's capacity is concentrated in large, low-barrier, congregate, crisis-oriented programs, and the same features that let those programs serve many people quickly, shared sleeping space, high turnover, and a focus on immediate need, can also make them difficult or unsafe for the people with the most specific requirements.

FINDING 23: Two-thirds of programs use a behavior-based approach to substance use.

About 66% of all programs (29 total) reported use some type of behavior-based model. This means they do not require sobriety, but they do expect residents to follow program expectations, not use substances on shelter property, and not be disruptive to others. This lower-barrier stance is common in the system, and it is the philosophy behind the ARCHES low-barrier network and most of the region's largest entry points.

At the other end of the spectrum, **16% of programs (7 total) require abstinence plus drug testing**, the highest-barrier category. These seven programs are a small share of programs but a much larger share of beds because the category includes the two largest single-gender congregate shelters in the region, Men's Mission at 248 beds and Simonka Place at 80.

Considering that 2025 Point-In-Time Count data shows at least **438 individuals with substance use disorder** in the regional system (sheltered and unsheltered), this concentration has real consequences for access. For someone who is not abstinent, a large block of the region's congregate capacity, including its single biggest shelter, is effectively closed.

Waitlist and occupancy data offer a further dimension to this picture, though with significant caveats given sparse reporting. Among the small number of programs that did report typical nightly occupancy, vacancy was concentrated almost entirely in the abstinence-required group: Simonka Place, Men's Mission, and VETCare together reported 95 unoccupied beds on a typical night, compared to just 14 across five behavior-based programs. While this data is too limited to draw firm conclusions, the pattern suggests that programs with the strictest entry requirements may be operating with more vacancy, while lower-barrier programs with waitlists turn people away — though this requires more investigation.

FINDING 24: Service availability varies by eligibility model.

Analyzing shelter programs by their eligibility requirements reveals that the most intensive services are concentrated in structured residential programs that require both **pre-entry**

sobriety and mandatory program participation. These programs tend to offer the broadest mix of wraparound supports case management, housing navigation, and mental health services and substance use treatment.

A second group **requires abstinence** but not structured program participation. Despite a high entry bar, these programs report offering fewer services than either of the other two categories. Case management is present at about half, and mental health services and employment services less likely.

The largest group — 29 programs operating under a **behavior-based model**, with on-site substance use policies but no pre-entry sobriety requirement — offers more consistent access to case management and housing navigation, the two services typically linked to housing exits. Still, mental health services, employment support, and substance use treatment, are less universal, suggesting that even the most accessible programs leave gaps in on site wraparound coverage. It's worth noting that some of these supports may be accessible off site through referral.

Table 24
Services by Eligibility Model

Program Model	N	Case Management	Housing Navigation	Mental / Behavioral Health	Employment Support	Substance Use Treatment
% of programs offering each service	Programs	% offering	% offering	% offering	% offering	% offering
Structured Pre-entry sobriety + participation requirement	3	67% (2/3)	67% (2/3)	100% (3/3)	67% (2/3)	100% (3/3)
Abstinence required Pre-entry sobriety, no participation requirement	7	57% (4/7)	43% (3/7)	14% (1/7)	29% (2/7)	57% (4/7)
Behavior-based On-site policy, no pre-entry sobriety requirement	29	76% (22/29)	66% (19/29)	48% (14/29)	38% (11/29)	28% (8/29)

Note: Programs with no detectable substance use or participation requirement excluded (n=5). Program model categories based on self-reported eligibility data. Findings are descriptive, not statistically generalizable.

Across all 44 programs, the **most common services** reflect a system built for crisis response: case management (70%), everyday essentials (68%), and housing navigation (57%). These services are nearly universal in emergency and low-barrier programs, confirming that the front door of the system is well equipped to connect people with help. The heatmap (Figure 24.2) confirms this concentration, with "emergency + low-barrier" combinations being the most service-dense, offering nine core services at near-universal rates. Beyond these crisis-oriented

offerings, though, the services that help people move toward stability are noticeably thinner: mental health support appears at about 41% of programs, employment assistance at 36%, recovery and substance use services at 34%, and rental assistance at 32%. The services that meet an immediate need are widespread, while those that build a bridge to stable housing and income reach only a third to half of programs.

Figure 24.1

Services Offered Across All 44 Programs

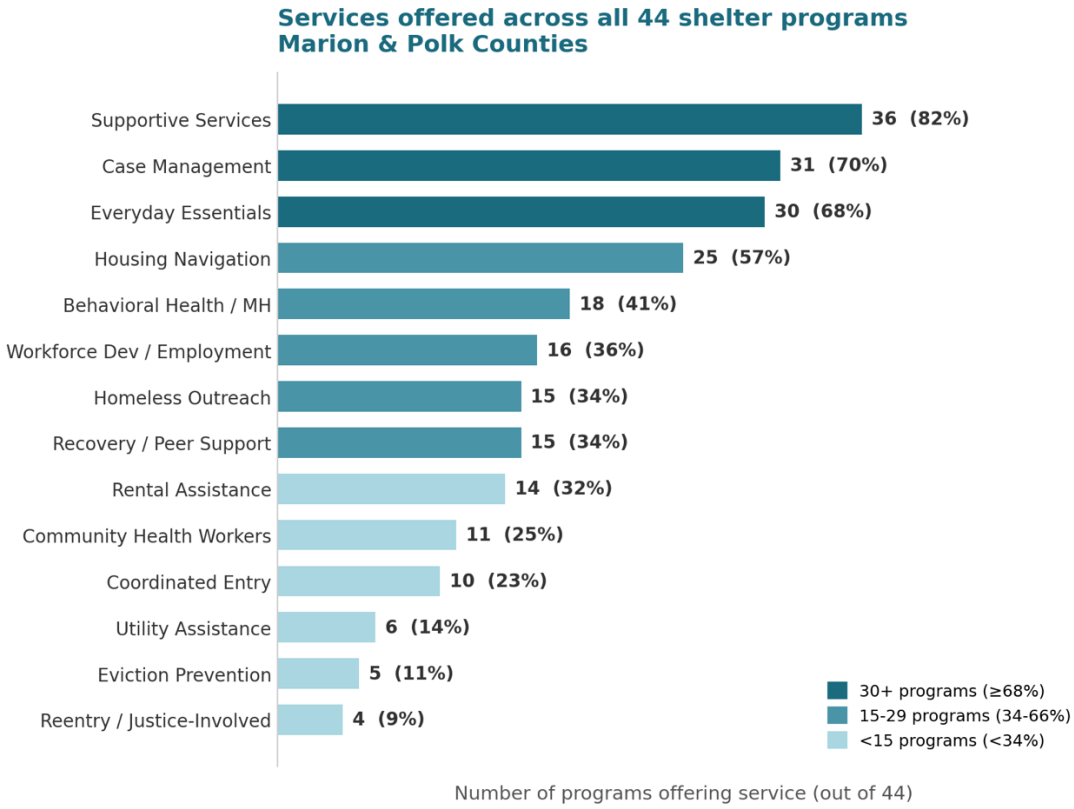
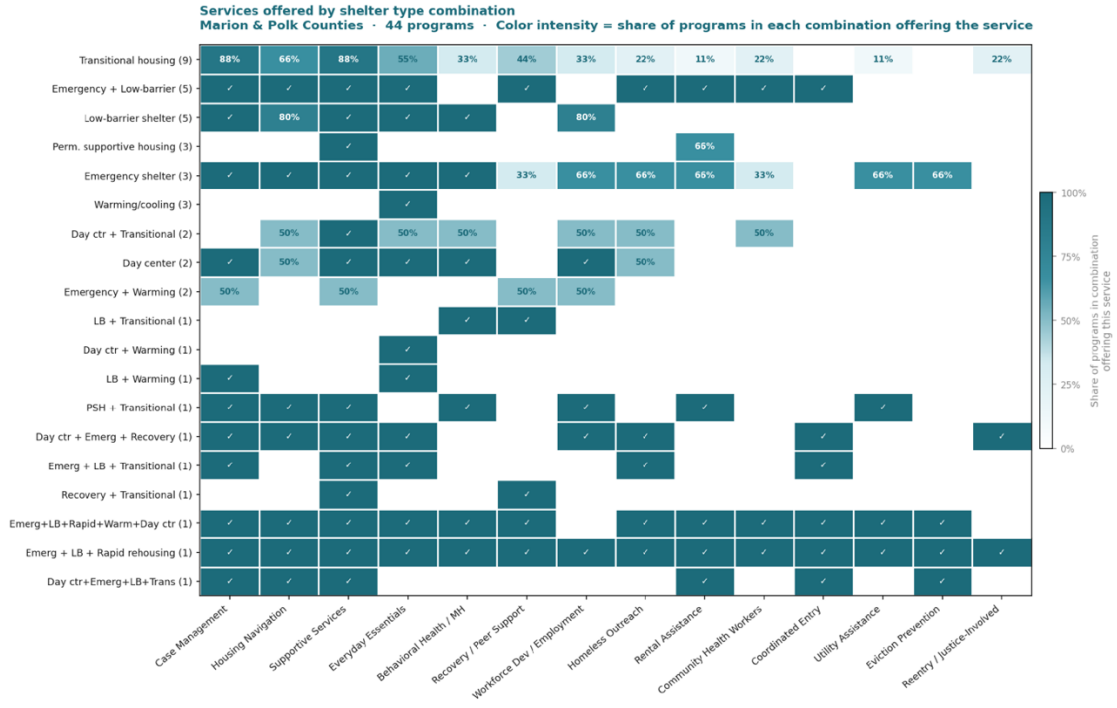


Figure 24.2

Heat Map: Services Offered by Shelter Type Combination



FINDING 25: Bunk beds and congregate beds make up about a third of sleeping spaces in shelters, limiting privacy.

About **30% of all beds in the system**, roughly 421 of 1,421, are bunk beds, and about a third are in congregate settings where residents sleep in shared rooms or open dormitories. Because bunk beds generally sit within congregate programs, these two figures overlap rather than add together. This means a substantial portion of the region's capacity offers little privacy or personal space. This is a significant barrier to safe and stable shelter for many of the people most likely to need it: survivors of domestic violence and others with trauma histories, for whom a crowded shared room can be retraumatizing; people in recovery, for whom close proximity to active substance use is a relapse risk; veterans and people in behavioral health crisis, who may struggle in high-stimulation environments; and people with mobility disabilities or older adults, for whom a bunk is often simply not usable, as noted in the accessibility finding. It’s important to note that at least two shelters — Center for Hope and Safety and Family Promise — said they can easily separate bunk beds to meet accessibility needs or reconfigure sleeping spaces. This offers some much-needed flexibility.

Congregate, bunk-bed programs are also the system's **largest and lowest-barrier front-door shelters.** Men's Mission (248 beds), the Salem Navigation Center (75 beds), and SafeSleep United (50 beds) are all congregate, so the very people who most need immediate, walk-in shelter are routed toward the least private options, while more private settings tend to be smaller, longer-term, or harder to enter. The effect is that a congregate bed can be counted as

available capacity and still be unusable for a given person's safety or recovery needs. Anecdotally, shelter representatives reported that maintaining recovery can be difficult even in private rooms with shared bathrooms, which suggests the privacy gap extends beyond the strictly congregate programs, and that the distance between "a bed exists" and "a bed this person can safely use" is finer than the totals imply.

Figure 25.1

Bunk Beds — Share of Total Bed Capacity

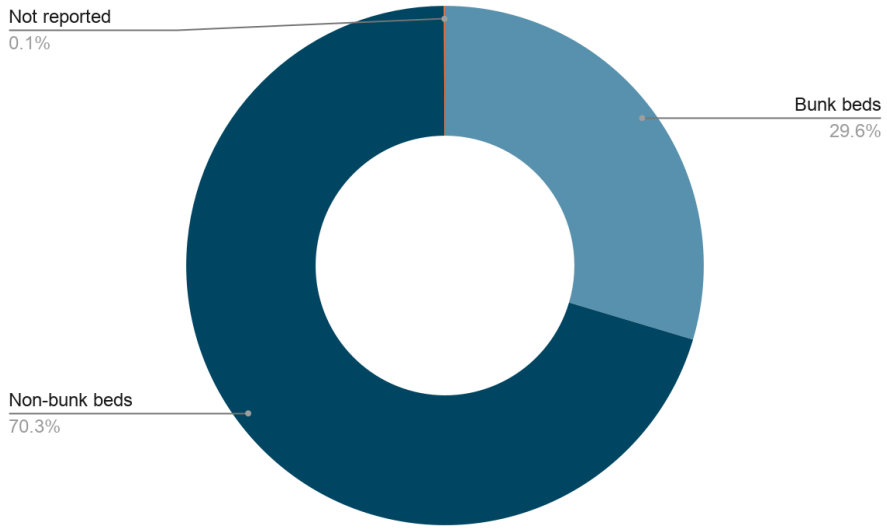
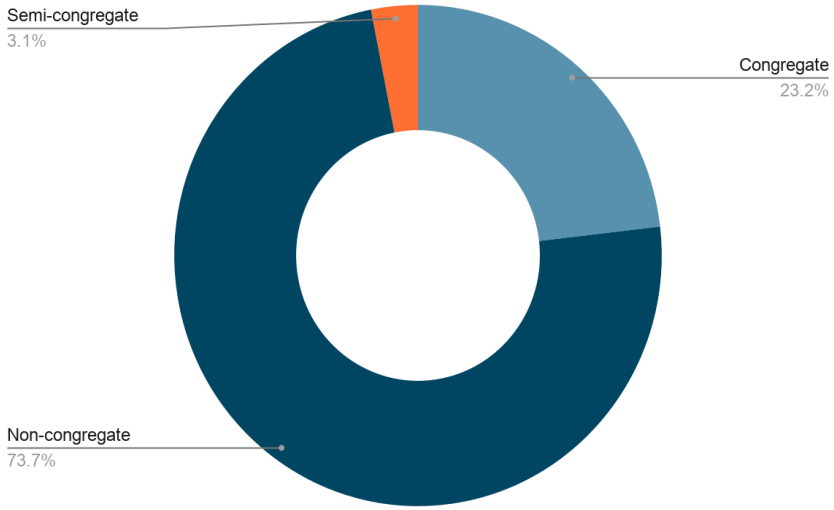


Figure 25.2

Congregate Beds — Share of Total Bed Capacity

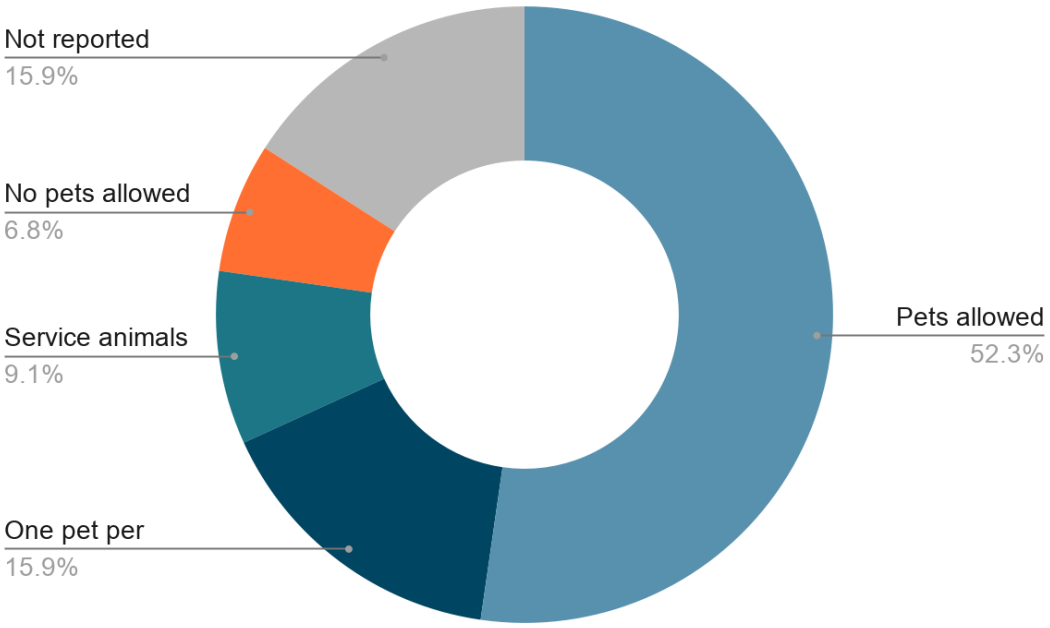


FINDING 26: The system is broadly pet friendly.

Thirty of 44 programs (68%) allow pets in some form, representing 781 beds and 201 households. This is a meaningful strength across the system, because pets are a well-documented reason people delay or decline shelter. For many people experiencing homelessness, a pet is a primary source of companionship, safety, and routine, and the prospect of surrendering or being separated from an animal may lead some to remain unsheltered rather than enter a program that will not take allow their pet. A system in which roughly two-thirds of programs accommodate animals therefore removes a barrier that, elsewhere, keeps people outside altogether.

Figure 26

Share of Programs that Allow Pets



KEY TAKEAWAYS

Section 5: Shelter Environment and Policies

1. A bed on paper is not always a bed a person can use.

The system's capacity concentrates in large, low-barrier, congregate, crisis-oriented programs, and the same features that let them serve many people quickly (shared sleeping space, high turnover, and a focus on immediate need) can make them difficult or unsafe for the people with the most specific requirements.

2. Most programs are low-barrier on substance use, but the strictest ones hold the most beds.

About **66%** of programs (29) use a behavior-based model with no sobriety requirement, yet the **16%** (7 programs) that require abstinence plus drug testing include the two largest congregate shelters (Men's Mission at 248 beds and Simonka Place at 80), so a large block of congregate capacity is effectively closed to anyone who is not abstinent.

3. The strictest programs may sit emptier while low-barrier programs turn people away.

Among the few programs reporting occupancy, abstinence-required shelters reported **95 empty beds** on a typical night versus just **14** across five behavior-based programs. The pattern warrants more investigation, given at least 438 people with substance use disorder counted in the region.

4. Services are built for crisis and thinner for the bridge to stability.

Case management (70%), everyday essentials (68%), and housing navigation (57%) are near-universal at the front door, but the services that move people toward stable housing and income lag: mental health at about **41%**, employment at 36%, recovery and substance use at 34%, and rental assistance at 32%.

5. About a third of beds offer little privacy, and they are the front-door beds.

Roughly **30%** of beds are bunks (421 of 1,421) and about a third are congregate, and the largest walk-in shelters (Men's Mission, Salem Navigation Center, SafeSleep United) are all congregate. The people who most need immediate shelter are routed to the least private options, which can be unsafe for survivors, people in recovery, and those with disabilities.

6. The system is broadly pet friendly.

30 of 44 programs (68%, representing 781 beds and 201 households) allow pets in some form, removing a well-documented barrier that otherwise keeps people from entering shelter.

Section 6: Funding and Data Infrastructure

This final section looks beneath the beds and policies to the financial and data foundations the system rests on, how programs are paid for and how well they can account for what they cost and whom they reach. These are less visible than bed counts, but they shape whether the system is stable, and whether it can even describe itself accurately. Two patterns emerge. The money is concentrated, with most programs leaning on a single dominant funder, and the data is inconsistent, with key measures like cost per bed reported too unevenly to support system-wide analysis. Together they point to a system that is functioning but fragile and not yet equipped to answer basic questions about its own efficiency and sustainability.

FINDING 27: Data on cost per bed is not sufficient for system-wide analysis.

Only **15 of 44 programs (34%) reported** an average operating cost per bed per night. Among those that did, the data varied widely with some reporting true operating costs, others reporting resident fees, monthly program charges, or total annual costs. Several of the largest programs, including Men's Mission (248 beds), SafeSleep United, Family Promise, and all four Permanent Supportive Housing (PSH) programs, explicitly noted they do not track cost in this way.

Among the 15 programs that did report cost per bed, costs ranged from $12/night (warming/cooling shelters) to $242/night (David's House, a 10-bed youth program). The **median cost-per-bed reported was $43/night**. This range reflects real differences in program intensity, scale, and population served. The highest per-bed costs are concentrated in small-scale, high-need programs serving youth and DV survivors, where intensive case management drives cost up and small bed counts leave little room for economies of scale. Standardizing cost-per-bed reporting across all programs would be a meaningful step toward understanding the true cost of the shelter system and making informed resource allocation decisions.

FINDING 28: State funding is the backbone of the system.

State funding anchors the system. **Seventy-five percent of programs (33 of 44) list the State of Oregon as a primary funding source**, and 12 programs are funded by the state alone. The reliance is greatest among the highest-capacity programs: State of Oregon Housing and Community Services (OHCS) investment in the ARCHES network alone is reported to exceed $6 million annually, so a single state agency underwrites a large share of the region's bed capacity. Two recovery-focused programs, Lupe's House and New Options, draw on Measure 110 funds, a stream that has recently undergone significant policy change. This means a state

budget reduction or policy shift could affect many of the system's largest programs at once, with little diversification to absorb the loss.

Local investment, by contrast, is thin. Only eight programs report city funding, only three report county funding, and about 32 of the 42 programs that disclosed their funding have no city or county support at all. The communities the system serves contribute relatively little of its operating base, which leaves programs without the local cushion that can steady them when state or federal dollars move.

Private and philanthropic funding fills part of the gap, but unevenly, and it concentrates risk in a different way. Several programs are heavily donor-dependent, including Family Promise (reported at about 68% privately funded), ARCHES Family First (built on a $5 million Bezos Day 1 Families Fund grant), Men's Mission, Simonka Place, and Women at the Well, some of which are essentially privately funded. Philanthropy of this kind can be generous but is rarely guaranteed year to year, so programs leaning on it carry their own instability.

Federal funding is widespread as a secondary source, appearing in the budgets of more than half of programs, but a handful are acutely dependent on it, and those tend to serve the most specialized populations. Sable House reports that roughly 80% of its budget is federal, the VETCare veterans home relies on VA per diem payments, and the region's youth programs, including David's House, draw federal youth-homelessness dollars. As a result, federal funding changes would fall hardest on the youth, domestic violence, and veteran programs, precisely the small, single-purpose providers the system can least afford to lose. Across every level of government and the private sector, the common thread is concentration: most programs lean on one dominant source, so the system is more exposed to a shift in any single funder than its overall size would suggest.

Figure 28.1

Primary Funding Sources for Sheltering Programs in Marion and Polk Counties

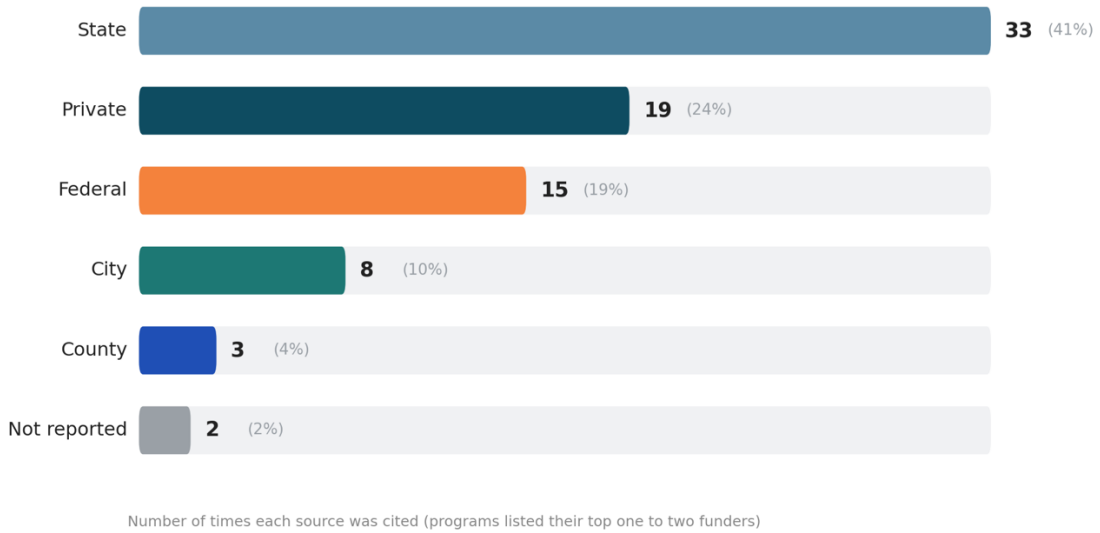
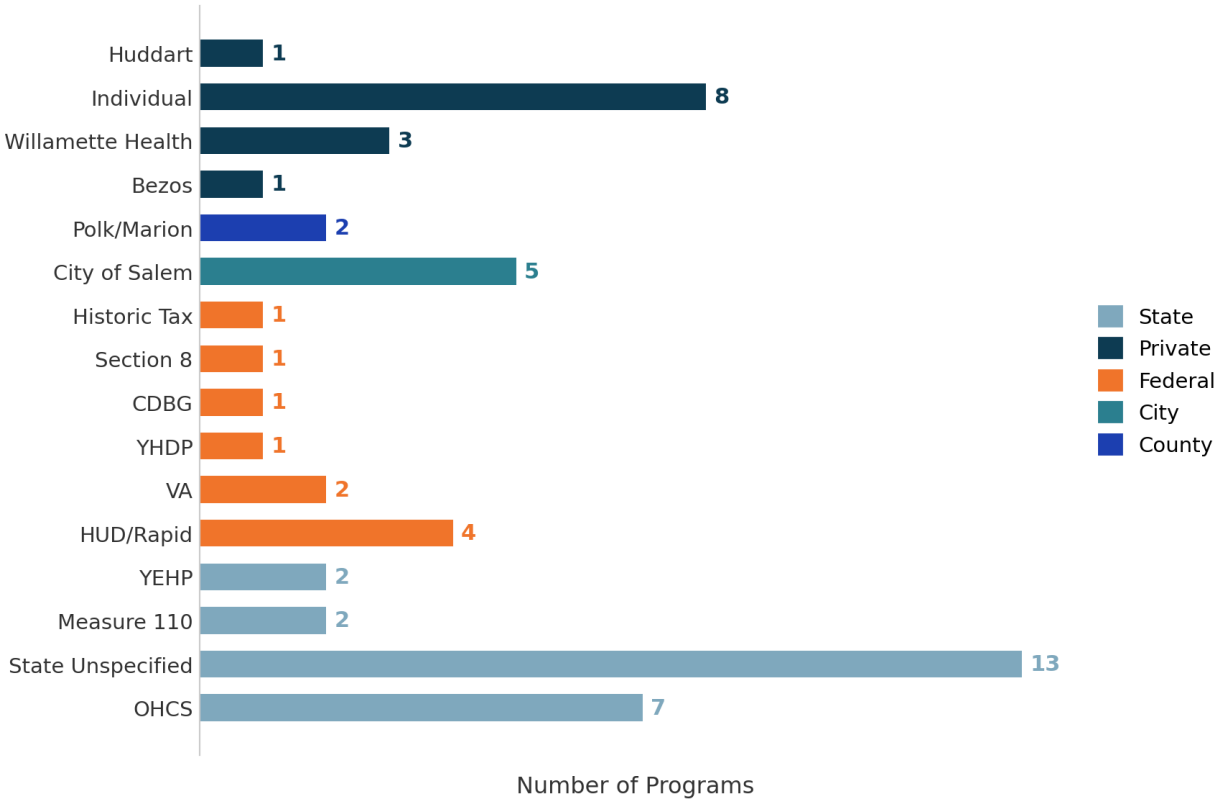


Figure 28.2

Specific Funding Sources Named by Programs



KEY TAKEAWAYS

Section 6: Funding and Data Infrastructure

1. The system cannot yet describe its own costs.

Only **15 of 44** programs (34%) reported a cost per bed, and even those mixed true operating costs with resident fees and annual totals. Several of the largest programs (Men's Mission and all four Permanent Supportive Housing programs) do not track cost this way, so the true cost of the system is unknown.

2. Where costs are reported, they vary too widely to compare.

Among the 15 reporting programs, cost per bed ranged from **$12/night** at warming shelters to **$242/night** at a 10-bed youth program (median **$43**), with the highest costs concentrated in small, high-need youth and DV programs rather than reflecting a comparable metric.

3. State dollars are the backbone, and the biggest single point of failure.

75% of programs (33 of 44) name the State of Oregon as a primary funder and 12 rely on it alone, with OHCS reportedly investing over **$6 million** a year in the ARCHES network, so one state budget or policy shift could destabilize many of the region's largest programs at once.

4. Local investment is thin.

Only **8 programs** report city funding and **3** report county funding, and about 32 of 42 disclosing programs have no local support at all, leaving the system without a local cushion when state or federal dollars move.

5. Private and federal money fill gaps but concentrate risk in the most vulnerable programs.

Several programs are heavily donor-dependent (Family Promise at about 68% private, ARCHES Family First built on a $5 million Bezos grant), while small providers serving youth, DV survivors, and veterans (Sable House at roughly 80% federal, VETCare on VA per diem) are acutely reliant on federal dollars, so the programs the system can least afford to lose are the most exposed.

6. The common thread is concentration: functioning but fragile.

Across state, local, private, and federal sources, most programs lean on a single dominant funder, so the system is more exposed to a shift in any one source than its size suggests, and it cannot yet answer basic questions about its own efficiency or sustainability.

Conclusion:

This landscape scan tells part of the story of homelessness and sheltering in Marion and Polk Counties, but not all of it. It maps the supply side of the system, the programs, beds, locations, and policies that make up the region's sheltering response, but it cannot speak to the lived experiences of people sleeping outside or moving in and out of housing instability, nor to the daily realities of the providers who serve them. Those perspectives are the work of the surveys and listening sessions still to come. What this scan offers is a broad-strokes foundation the rest of the community needs assessment can build on, and even at this level it reveals clear strengths alongside significant gaps.

The system's strengths are real. The region has built strong low-barrier capacity, with 311 beds across five programs that share a consistent Housing First philosophy, pet-friendly policies, bilingual staffing, and behavior-based substance use approaches. The emergency and low-barrier programs that anchor the system offer a dense set of wraparound services, including case management, housing navigation, behavioral health support, and outreach. Around-the-clock access is the norm rather than the exception, with 25 of 44 programs operating 24/7 and covering most emergency, low-barrier, and family beds, which matters most for the domestic violence programs where safety depends on it. Spanish-language access is comparatively broad, reaching roughly three-quarters of programs in some form. The system is also broadly pet-friendly, with about 68% of programs accommodating animals and removing a well-documented barrier to shelter. And family-friendly capacity exists across the continuum, with 230 household units spread across emergency, transitional, and Permanent Supportive Housing (PSH).

The gaps are just as clear. On paper the system's combined capacity nearly matches the Point-in-Time count, but that near-parity is misleading, because most programs report waitlists and the Point-in-Time count is itself a known undercount. Also, when we look closer at specific populations, we see that veterans and adults with children are the only notable exception to a pattern of undersupply. The transitional middle is thin, spread across smaller-capacity providers, which leaves a narrow pipeline for people ready to move beyond emergency shelter. Capacity dedicated to youth is critically limited, with just 20 beds across two residential programs. And family intake is often gated behind appointment-only or online-only processes, leaving little walk-in pathway for families in acute crisis.

Access and equity gaps run throughout the system. Only about a third of programs are walk-in accessible, while the rest require a referral, an appointment, or internet access. Capacity, services, language access, and 24/7 programs are heavily concentrated in Salem, leaving the impression that Polk County and rural Marion County may be underserved. Language access beyond Spanish is insufficient for the region's diversity, with Russian available at only four programs, sign language at three, Marshallese at two, Chinese and Vietnamese at one each, and Chuukese at none. The inventory captures little about who is served beyond “all races and ethnicities,” making equity in access and outcomes difficult to assess from this data alone. The system contains no LGBTQIA+ specific programming, and physical accessibility for people with

disabilities is documented inconsistently, so it’s difficult to say how many beds are usable by someone with a mobility disability. Faith-based organizations operate a substantial share of the region's congregate beds, concentrated in its largest and highest-barrier programs, which raises access questions this scan can identify but not yet answer. And reentry and justice-involved services remain limited, offered by only a handful of programs and never as a dedicated focus.

Two systemic risks stand out. The system depends heavily on state funding, with 75% of programs relying on it, 12 funded by the state alone, and almost no local city or county investment to cushion against shifts in the state budget. And the data infrastructure itself is fragmented, with 13 programs not on HMIS, inconsistent reporting on key metrics like cost per bed, and no way to produce a system-level unduplicated count.

Taken together, these findings describe a system that has built meaningful strengths at the front door of crisis response while leaving real gaps in its middle, in its geographic accessibility, and in its capacity to serve specific populations equitably. Many of these gaps are not failures of execution but questions this supply-side scan was not designed to answer, questions of lived experience, demographic equity, and provider capacity that the surveys and listening sessions to come are built to explore. Together they will give MWVCAA a fuller basis for the regional planning this assessment is designed to inform.

Appendix A:

Shelter Inventory by Shelter Type Combination

On a typical night, Marion and Polk county shelter programs provide **1,421 unique beds**, plus housing units or rooms serving **230 unique households** across **44 verified programs.**

Shelter type combination	Programs	#	Adults only	Adults w/ children	Youth (11-17)	DV survivors	Total beds	Total HH
			beds / HH	*beds / HH*	*beds / HH*	*beds / HH*		
Transitional housing	New Options · Village One · Village Two · Gale's Lodge · Women at the Well · St. Joseph Family Shelter · Father Taaffe Homes · Ediger Hall · St. Francis Family Housing	**9**	33 beds	76 beds / 41 HH	—	—	**109**	**41**
Emergency shelter + Low-barrier shelter	Family Site Dallas House · Family Shelter Community (CCS) · Monmouth Adult Shelter · Village of Hope · Young Adult Shelter Community	**5**	100 beds / 19 HH	51 HH	—	—	**100**	**70**
Low-barrier shelter	ARCHES Lodge · ARCHES Inn · Salem Navigation Center · The ARCHES Nest · David's House	**5**	265 beds	36 beds	10 beds	—	**311**	—
Permanent Supportive Housing	Coral Women's House · Redwood Crossings · Sequoia Crossing · Yaquina Hall	**4**	65 beds†	112 HH	—	—	**65†**	**112**
† *Includes 6 recovery-based shelter beds at Redwood Crossings operated in collaboration with Bridgeway Health.*								
Emergency shelter	Warriors of Hope · Taylor's House · Sable House	**3**	—	7 HH	10 beds	10 beds	**20**	**7**
Warming/cooling shelter	Polk County Warming Centers · ARCHES Mill City · ARCHES Salem First Presbyterian	**3**	—	—	—	—	**117†**	—
† *All 117 beds are seasonal warming/cooling beds (Polk County Warming Centers 20, ARCHES Mill City 0 reported, ARCHES Salem First Presbyterian 97). Not available year-round.*								
Day center + Transitional housing	HOST · CRAWL	**2**	48 beds	—	—	—	**48**	—
Day center	Next Steps Youth Day Center · ARCHES Family First	**2**	—	—	—	—	—	—
Emergency shelter + Warming/cooling shelter	Seed of Faith Ministries · Simonka Place	**2**	—	220 beds	—	—	**220 + 80†**	—
† *220 year-round beds. An additional 80 seasonal warming beds (Seed of Faith Ministries) are available during inclement weather.*								

Shelter type combination	Programs	#	Adults only	Adults w/ children	Youth (11-17)	DV survivors	Total beds	Total HH
			beds / HH	*beds / HH*	*beds / HH*	*beds / HH*		
Low-barrier shelter + Transitional housing	Lupe's House	**1**	9 beds	—	—	—	**9**	—
Day center + Warming/cooling shelter	The ARCHES Day Center	**1**	—	—	—	—	**30†**	—
† *30 seasonal warming beds only — activated during inclement weather. No year-round overnight capacity.*								
Low-barrier shelter + Warming/cooling shelter	ARCHES Woodburn Overnight	**1**	20 beds	—	—	—	**20 + 20†**	—
† *20 year-round overnight beds plus 20 additional seasonal warming beds during inclement weather.*								
Day center + Emergency shelter + Recovery-focused shelter	Men's Mission	**1**	248 beds	—	—	—	**248**	—
Emergency shelter + Low-barrier shelter + Transitional housing	SafeSleep United Women's Shelter	**1**	—	50 beds	—	—	**50**	—
Recovery-focused shelter + Transitional housing	VETCare Veterans Home	**1**	30 beds	—	—	—	**30**	—
Emergency + Low-barrier + Rapid rehousing + Warming + Day center	Sheltering Silverton	**1**	—	22 beds	—	—	**22**	—
Emergency shelter + Low-barrier shelter + Rapid rehousing	Center for Hope and Safety	**1**	—	—	—	120 beds	**120**	—
Day center + Emergency + Low-barrier shelter + Transitional housing	Family Promise	**1**	—	49 beds	—	—	**49**	—
Total	44 programs	**44**	—	—	—	—	**1,421**	**230**

Notes: Each program appears exactly once under its exact shelter type combination as recorded in the Shelter Inventory. Beds = individual sleeping spaces (non-inclement/year-round). HH = households; 1 HH ≠ 1 bed. Population columns show beds and/or households where applicable. † Seasonal warming/cooling beds are activated during inclement weather only and are not included in the 1,421 year-round bed total. An additional 247 warming beds are available system-wide during inclement weather, bringing total inclement weather capacity to 1,668 beds.

Appendix B:

Overview of Shelter Capacity

Measure	Count	Notes
Combined Capacity Estimates · HH × 3 per household (conservative estimate)		
Typical combined shelter bed capacity	**2,111 beds**	*1,421 beds + 690 est. individuals in HH (230 HH × 3)*
Inclement weather combined capacity	**2,358 beds**	*1,668 beds + 690 est. individuals in HH (230 HH × 3)*
Individual beds added during inclement weather (warming beds)	247 beds	*Polk County Warming Centers (20) · ARCHES Woodburn +20 · ARCHES Day Center (30) · Seed of Faith (80) · ARCHES Salem First Presbyterian (97)*
Typical Capacity (non-inclement weather, year-round programs)		
Total programs	38	*Programs that operate year-round capacity*
Individual beds	1,421	*Non-inclement individual sleeping spaces*
Family units (households)	230	*1 HH ≠ 1 bed — family units of varying sizes*
Est. individuals in family units (households)	690	*230 HH × 3 (conservative)*
Inclement Weather Capacity (includes seasonal warming beds)		
Total programs	44	*All programs*
Individual beds	1,668	*1,421 year-round + 247 seasonal warming beds*
Family units (households)	230	*No additional HH units during inclement weather*
Est. individuals in HH	690	*230 HH × 3 — unchanged from typical*

Notes: Individual beds and households are reported as separate units — 1 HH ≠ 1 bed. Combined capacity estimates convert households to individuals using a conservative assumption of 3 persons per household. Seasonal warming beds are activated during inclement weather only and are not available year-round. Combined capacity estimates do not equal the number of unique individuals experiencing homelessness who are sheltered — PIT counts undercount actual homelessness and reported capacity does not account for eligibility restrictions, geographic access, or waitlists.

Appendix C:

Polk and Marion County Sheltering Service Inventory | 44 Programs

Program name	Organization	Address	Emerg.	Low-barrier	Warm/cool	Trans-itional	PSH	Recovery	Daycenter	Rapid rehousing	Adults only	Adults w/children	Youth	DV survivors
ARCHES Family First	Mid-Willamette Valley Community Action Agency	1255 Broadway St NE, 110, Salem, OR 97301	☐	☐	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐
ARCHES Inn	Mid-Willamette Valley Community Action Agency	1288 Hawthorne Ave NE, Salem, OR 97301	☐	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐
ARCHES Lodge	Mid-Willamette Valley Community Action Agency	1875 Fisher Road NE, Salem, OR 97305	☐	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐
Center for Hope and Safety		605 Center St. NE, Salem (Advocacy Office)	☑	☑	☐	☐	☐	☐	☐	☑	☐	☐	☐	☑
Coral Women's House	Church at the Park	2550 Coral Ave NE, Salem, Oregon	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐	☐	☐
CRAWL (Community, Recovery and Wellness Living)	Seed of Faith Ministries	853 Medical Center Dr NE, Salem, OR 97301	☐	☐	☐	☑	☐	☐	☑	☐	☑	☐	☐	☐
David's House	Mid-Willamette Valley Communication Action Agency	719 E Jackson St., Monmouth, OR 97361	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
Ediger Hall	Polk County Family & Community Outreach	450 SE Washington St, Dallas, OR 97338	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐
Family Promise of the Mid-Willamette Valley		1055 NW Edgewater St. Salem, OR 97304	☑	☑	☐	☑	☐	☐	☑	☐	☐	☑	☐	☐
Family Shelter Community (CCS)	Church at the Park	3749 Portland Rd, northeast Salem, OR	☑	☑	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐
Family Site Dallas House	Church at the Park	1876 SE Holman Ave. Dallas, OR 97338	☑	☑	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐
Gale's Lodge	Polk County Family & Community Outreach	565 SE Lacreole Dr., Dallas, OR 97338	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	☐	☐
HOST (Health, Outreach, Shelter, Transitions)	Northwest Human Services	1143 Liberty St NE, Salem, OR 97301	☐	☐	☐	☑	☐	☐	☑	☐	☑	☐	☐	☐
Lupe's House	Bridgeway Community Health	750 Front Street NE Salem, OR 97301	☐	☑	☐	☑	☐	☐	☐	☐	☑	☐	☐	☐

Program name	Organization	Address	Emerg.	Low-barrier	Warm/cool	Trans-itional	PSH	Recovery	Daycenter	Rapid rehousing	Adults only	Adults w/children	Youth	DV survivors
Men's Mission (New Life Fellowship is Program within the shelter)	Union Gospel Mission of Salem	777 Commercial St NE, Salem, OR 97301	☑	☐	☐	☐	☐	☑	☑	☐	☑	☐	☐	☐
Monmouth Adult Shelter	Church at the Park	300 Stadium NE. Monmouth, OR 97361	☑	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐
New Options	Bridgeway Community Health	3500 Hawthorne Ave. NE, Salem, OR 97301	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐
Next Steps Youth Day Center	Mid-Willamette Valley Communication Action Agency	2551 Pringle Rd. SE, Salem, Oregon 97302	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐
Polk County Warming Centers	Mid-Willamette Valley Community Action Agency	Rotating Locations: St. Thomas Episcopal (1486 SW Levens St., Dallas), Dallas Church (450 SE Washington St.), Praise Church / Puerta De Fe / Community Life (189 Monmouth Ave. S),	☐	☐	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐
Redwood Crossings	Salem Housing Authority	4107 Fisher Road NE, Salem, Oregon 97305	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐	☐	☐
Sable House		314 SE Oak St. Dallas, OR 97338 (Advocacy Office, Mailing Address is different)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑
SafeSleep United Women's Shelter	United Way Mid-Willamette Valley	1910 NE Front St. NE, Salem, Oregon 97301	☑	☑	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐
Salem Navigation Center	Mid-Willamette Valley Community Action Agency	1185 22nd Street SE, Salem 97302	☐	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐
Seed of Faith Ministries (Warming and Cooling Shelter)	Seed of Faith Ministries	1248 Winter Street, NE, Salem, OR 97301	☑	☐	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐
Sequoia Crossings	Salem Housing Authority	2950 Broadway Street NE, Salem OR 97303	☐	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	☐
Sheltering Silverton		830B McClaine St. Silverton, OR 97381	☑	☑	☑	☐	☐	☐	☑	☑	☐	☑	☐	☐
Simonka Place	Union Gospel Mission	5119 River Road N, Keizer, OR 97303	☑	☐	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐
St. Francis Family Housing		1820 Berry St, Salem, OR 97302	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐

Program name	Organization	Address	Emerg.	Low-barrier	Warm/cool	Trans-itional	PSH	Recovery	Daycenter	Rapid rehousing	Adults only	Adults w/children	Youth	DV survivors
St. Joseph Family Shelter	Catholic Community Services	925 S Main St. Mount Angel, OR 97362	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐
Taylor's House	Mid-Willamette Valley Communication Action Agency	220 15th St. SE Salem OR 97301	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
The ARCHES Day Center	Mid-Willamette Valley Community Action Agency	615 Commercial St NE, Salem, OR 97301	☐	☐	☑	☐	☐	☐	☑	☐	☑	☐	☐	☐
The ARCHES Nest	Mid-Willamette Valley Community Action Agency	2933 Center Street NE, Salem, OR 97301	☐	☑	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐
The ARCHES Project: Mill City Resource Center Warming Site	Mid-Willamette Valley Community Action Agency	280 NE Santiam Blvd., Mill City, OR 97360	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐	☐
The ARCHES Project: Salem First Presbyterian Church Warming Site (Marion County Warming)	Mid-Willamette Valley Community Action Agency	770 Chemeketa St NE, Salem, OR 97301	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐	☐
The ARCHES Project: Woodburn Overnight Shelter and Warming Center	Mid-Willamette Valley Community Action Agency	1560 Hardcastle Ave. Woodburn, OR 97071	☐	☑	☑	☐	☐	☐	☐	☐	☑	☐	☐	☐
The Father Taaffe Homes Program	Catholic Community Services	Queen of Angels Monastery 840 S Main St, Mt Angel, OR 97362	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐
VETCare Veterans Home (transitional housing)	VETcare Westcare Oregon	2933 NE Center St., Salem, OR 97301	☐	☐	☐	☑	☐	☑	☐	☐	☑	☐	☐	☐
Village of Hope Adult Shelter Community (VOH)	Church at the Park	1280 Center St N.E	☑	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐
Village One (Tiny Homes/Pods)	Confederated Tribes of Grand Ronde	Off Hwy 22 in Salem	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	☐	☐
Village Two (Tiny Homes/Pods)	Confederated Tribes of Grand Ronde	N/A	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐
Warriors of Hope	Confederated Tribes of Grand Ronde	9615 Grand Ronde Road, Grand Ronde, OR 97347	☑	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐
Women at the Well Grace House		1243 SE Peace St. Salem, OR 97302	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	☐	☐
Yaquina Hall	Salem Housing Authority	2720 B ST NE, Salem, OR 97301	☐	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	☐

Program name	Organization	Address	Emerg.	Low-barrier	Warm/cool	Trans-itional	PSH	Recovery	Daycenter	Rapid rehousing	Adults only	Adults w/children	Youth	DV survivors
Young Adult Shelter Community (YAS)	Church at the Park	2410 Turner Road SE in Salem, Oregon,	☑	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐

Notes: Shelter types and primary populations reflect program self-reporting in the landscape scan. Organization name shown where different from program name. Emerg. = Emergency shelter · LB = Low-barrier shelter · Warm/cool = Warming/cooling shelter · Trans. = Transitional housing · PSH = Permanent Supportive Housing.

Appendix D:

Shelter Inventory Questions

ORGANIZATION & POPULATION SERVED

1. How would you characterize the type of shelter that your program provides?
    a. Day center
    b. Emergency shelter
    c. Low-barrier shelter
    d. Rapid rehousing
    e. Warming/cooling shelter
    f. Transitional housing
    g. Permanent supportive housing
    h. Recovery-focused shelter
    i. Something else?
2. What services do you offer the individuals served in your shelter?
    a. utility assistance
    b. eviction prevention
    c. rental assistance
    d. recovery services/peer support
    e. housing navigation
    f. community health workers
    g. supportive services
    h. outreach
3. Does your program only serve individuals of a specific gender? If so, which genders does your program serve?
4. What age groups does your program serve? Do you provide services to families with children under 18?
5. Is your organization faith-based? (Y/N) If yes, what is your religious affiliation?
6. Is your program culturally specific? (Y/N) If yes, which racial or ethnic communities does your program primarily serve?
7. Do you serve any other specific populations (e.g., veterans, LGBTQ+ individuals, survivors of domestic violence)?
8. What language(s) are spoken at your location? Do you have bilingual staff/advocates on site? Do you offer interpretation services?
9. What are your operating hours?
10. What is your capacity on a typical night (# of beds available)? Are any of these beds in a congregate setting? How many (if any) of these beds are bunk beds?
11. Is there typically a waitlist for services? (Y/N) If not, how many beds are left unoccupied on a typical night?
12. What is the average operating cost per bed per night (if available)?
13. Approximately how many unique individuals does your program serve in a year?
14. Does your organization use HMIS to track client data? (Y/N)

ELIGIBILITY & ACCESS

15. What does your eligibility and intake process look like? Please share any details that apply:
    a. How do people access your services? (e.g., walk-in, online form, referral)
    b. Are pets allowed? If so, are there any restrictions on type or size?
    c. Are children allowed?
    d. Do you have any drug testing or substance use policies?
    e. Is your site ADA accessible?
    f. Are there any other eligibility requirements we should know about?

OUTREACH & FUNDING

16. What are the primary ways your shelter or program connects with people experiencing homelessness?
17. What are your top 1-2 primary funding sources?
18. Approximately how much funding does your organization receive from those top sources? (provide approximate dollar amount)

Appendix E:

Shelter Inventory Data Sources

All data collection and validation methods were attempted. Check marks in the table below indicate each data validation method that was completed and/or received a valid response.

Program name	Organization	Internet Research	Quick Verify Staff Phone Call	In-Depth Leadership Phone Call or Email	Email Verify with Leadership
ARCHES Family First	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☑
ARCHES Inn	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☑
ARCHES Lodge	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☑
Center for Hope and Safety		☑	☑	☑	☑
Coral Women's House	Church at the Park	☑	☐	☑	☐
CRAWL (Community, Recovery and Wellness Living)	Seed of Faith Ministries	☑	☑	☑	☑
David's House	Mid-Willamette Valley Communication Action Agency	☑	☐	☑	☑
Ediger Hall	Polk County Family & Community Outreach	☑	☐	☑	☐
Family Promise of the Mid-Willamette Valley		☑	☑	☑	☑
Family Shelter Community (CCS)	Church at the Park	☑	☑	☑	☑
Family Site Dallas House	Church at the Park	☑	☑	☐	☐
Gale's Lodge	Polk County Family & Community Outreach	☑	☐	☑	☑
HOST (Health, Outreach, Shelter, Transitions)	Northwest Human Services	☑	☑	☑	☑
Lupe's House	Bridgeway Community Health	☑	☐	☑	☑
Men's Mission (New Life Fellowship is Program within the shelter)	Union Gospel Mission of Salem	☑	☑	☑	☐
Monmouth Adult Shelter	Church at the Park	☑	☐	☑	☑
New Options	Bridgeway Community Health	☑	☐	☑	☑
Next Steps Youth Day Center	Mid-Willamette Valley Communication Action Agency	☑	☐	☑	☑
Polk County Warming Centers	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☑
Redwood Crossings	Salem Housing Authority	☑	☐	☑	☐
Sable House		☑	☑	☑	☑

Program name	Organization	Internet Research	Quick Verify Staff Phone Call	In-Depth Leadership Phone Call or Email	Email Verify with Leadership
SafeSleep United Women's Shelter	United Way Mid-Willamette Valley	☑	☑	☑	☑
Salem Navigation Center	Mid-Willamette Valley Community Action Agency	☑	☑	☑	☐
Seed of Faith Ministries (Warming and Cooling Shelter)	Seed of Faith Ministries	☑	☑	☑	☑
Sequoia Crossings	Salem Housing Authority	☑	☐	☑	☐
Sheltering Silverton		☑	☑	☑	☑
Simonka Place	Union Gospel Mission	☑	☑	☑	☐
St. Francis Family Housing		☑	☑	☑	☑
St. Joseph Family Shelter	Catholic Community Services	☑	☐	☑	☑
Taylor's House	Mid-Willamette Valley Communication Action Agency	☑	☐	☑	☑
The ARCHES Day Center	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☐
The ARCHES Nest	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☑
The ARCHES Project: Mill City Resource Center Warming Site	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☐
The ARCHES Project: Salem First Presbyterian Church Warming Site (Marion County Warming)	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☑
The ARCHES Project: Woodburn Overnight Shelter and Warming Center	Mid-Willamette Valley Community Action Agency	☑	☐	☑	☑
The Father Taaffe Homes Program	Catholic Community Services	☑	☐	☑	☑
VETCare Veterans Home (transitional housing)	VETcare Westcare Oregon	☑	☑	☑	☐
Village of Hope Adult Shelter Community (VOH)	Church at the Park	☑	☐	☑	☑
Village One (Tiny Homes/Pods)	Confederated Tribes of Grand Ronde	☑	☐	☐	☐
Village Two (Tiny Homes/Pods)	Confederated Tribes of Grand Ronde	☑	☐	☐	☐
Warriors of Hope	Confederated Tribes of Grand Ronde	☑	☐	☑	☐
Women at the Well Grace House		☑	☐	☑	☑
Yaquina Hall	Salem Housing Authority	☑	☐	☑	☐
Young Adult Shelter Community (YAS)	Church at the Park	☑	☐	☑	☑

Appendix F:

Organization snapshots of sheltering services

These snapshots group the 44 sheltering programs by the 18 organizations that operate them. Each entry lists the organization, its programs, the address and capacity of each program, the service types it provides, and the populations it serves. Appendix C presents the same programs as a single categorized inventory.

Mid-Willamette Valley Community Action Agency

13 programs · **341 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
ARCHES Family First 1255 Broadway St NE, 110, Salem, OR 97301 Not reported	–	–	–	–	–	–	✓	–	Families
ARCHES Inn 1288 Hawthorne Ave NE, Salem, OR 97301 106 beds	–	✓	–	–	–	–	–	–	Adults only
ARCHES Lodge 1875 Fisher Road NE, Salem, OR 97305 84 beds	–	✓	–	–	–	–	–	–	Adults only
David's House 719 E Jackson St., Monmouth, OR 97361 10 beds	–	✓	–	–	–	–	–	–	Youth (11-17)
Next Steps Youth Day Center 2551 Pringle Rd. SE, Salem, Oregon 97302 Not reported	–	–	–	–	–	–	✓	–	Youth (11-17)
Polk County Warming Centers Rotating Locations: St. Thomas Episcopal (1486 SW Levens St., Dallas), Dallas Church (450 SE Washington St.), Praise Church / Puerta De Fe / Community Life (189 Monmouth Ave. S) 20 warming beds	–	–	✓	–	–	–	–	–	Families
Salem Navigation Center 1185 22nd Street SE, Salem 97302 75 beds	–	✓	–	–	–	–	–	–	Adults only
Taylor's House 220 15th St. SE Salem OR 97301 10 beds	✓	–	–	–	–	–	–	–	Youth (11-17)
The ARCHES Day Center 615 Commercial St NE, Salem, OR 97301 30 warming	–	–	✓	–	–	–	✓	–	Adults only

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
The ARCHES Nest 2933 Center Street NE, Salem, OR 97301 **36 beds**	–	✓	–	–	–	–	–	–	Families
The ARCHES Project: Mill City Resource Center Warming Site 280 NE Santiam Blvd., Mill City, OR 97360 Not reported	–	–	✓	–	–	–	–	–	Adults only
The ARCHES Project: Salem First Presbyterian Church Warming Site (Marion County Warming) 770 Chemeketa St NE, Salem, OR 97301 **97 warming beds**	–	–	✓	–	–	–	–	–	Adults only
The ARCHES Project: Woodburn Overnight Shelter and Warming Center 1560 Hardcastle Ave. Woodburn, OR 97071 **20 beds (+20 warming)**	–	✓	✓	–	–	–	–	–	Adults only

Church at the Park

6 programs · **128 beds** · **70 households**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Coral Women's House 2550 Coral Ave NE, Salem, Oregon **28 beds**	–	–	–	–	✓	–	–	–	Adults only
Family Shelter Community (CCS) 3749 Portland Rd, northeast Salem, OR **49 households**	✓	✓	–	–	–	–	–	–	Families
Family Site Dallas House 1876 SE Holman Ave. Dallas, OR 97338 **2 households**	✓	✓	–	–	–	–	–	–	Families
Monmouth Adult Shelter 300 Stadium NE. Monmouth, OR 97361 **20 beds**	✓	✓	–	–	–	–	–	–	Adults only
Village of Hope Adult Shelter Community (VOH) 1280 Center St N.E **80 beds**	✓	✓	–	–	–	–	–	–	Adults only
Young Adult Shelter Community (YAS) 2410 Turner Road SE in Salem, Oregon **19 households**	✓	✓	–	–	–	–	–	–	Adults only

Confederated Tribes of Grand Ronde

3 programs · **80 beds** · **7 households**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Village One (Tiny Homes/Pods) Off Hwy 22 in Salem **20 beds**	–	–	–	✓	–	–	–	–	Adults only
Village Two (Tiny Homes/Pods) **60 beds**	–	–	–	✓	–	–	–	–	Families
Warriors of Hope 9615 Grand Ronde Road, Grand Ronde, OR 97347 **7 households**	✓	–	–	–	–	–	–	–	Families

Salem Housing Authority

3 programs · **37 beds** · **112 households**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Redwood Crossings 4107 Fisher Road NE, Salem, Oregon 97305 **37 beds**	–	–	–	–	✓	–	–	–	Adults only
Sequoia Crossings 2950 Broadway Street NE, Salem OR 97303 **60 households**	–	–	–	–	✓	–	–	–	Families
Yaquina Hall 2720 B ST NE, Salem, OR 97301 **52 households**	–	–	–	–	✓	–	–	–	Families

Bridgeway Community Health

2 programs · **25 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Lupe's House 750 Front Street NE Salem, OR 97301 **9 beds**	–	✓	–	✓	–	–	–	–	Adults only
New Options 3500 Hawthorne Ave. NE, Salem, OR 97301 **16 beds**	–	–	–	✓	–	–	–	–	Families

Catholic Community Services

2 programs · **21 households**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
St. Joseph Family Shelter 925 S Main St. Mount Angel, OR 97362 **6 households**	–	–	–	✓	–	–	–	–	Families
The Father Taaffe Homes Program Queen of Angels Monastery 840 S Main St, Mt Angel, OR 97362 **15 households**	–	–	–	✓	–	–	–	–	Families

Polk County Family & Community Outreach

2 programs · **5 beds** · **1 household**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Ediger Hall 450 SE Washington St, Dallas, OR 97338 **1 household**	–	–	–	✓	–	–	–	–	Families
Gale's Lodge 565 SE Lacreole Dr., Dallas, OR 97338 **5 beds**	–	–	–	✓	–	–	–	–	Adults only

Seed of Faith Ministries

2 programs · **172 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
CRAWL (Community, Recovery and Wellness Living) 853 Medical Center Dr NE, Salem, OR 97301 **32 beds**	–	–	–	✓	–	–	✓	–	Adults only
Seed of Faith Ministries (Warming and Cooling Shelter) 1248 Winter Street, NE, Salem, OR 97301 **140 beds (+80 warming)**	✓	–	✓	–	–	–	–	–	Families

Union Gospel Mission

2 programs · **328 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Men's Mission (New Life Fellowship is Program within the shelter) 777 Commercial St NE, Salem, OR 97301 **248 beds**	✓	–	–	–	–	✓	✓	–	Adults only
Simonka Place 5119 River Road N, Keizer, OR 97303 **80 beds**	✓	–	✓	–	–	–	–	–	Families

Center for Hope and Safety

1 program · **120 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Center for Hope and Safety 605 Center St. NE, Salem (Advocacy Office) **120 beds**	✓	✓	–	–	–	–	–	✓	DV survivors

Family Promise of the Mid-Willamette Valley

1 program · **49 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Family Promise of the Mid-Willamette Valley 1055 NW Edgewater St. Salem, OR 97304 **49 beds**	✓	✓	–	✓	–	–	✓	–	Families

Northwest Human Services

1 program · **16 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
HOST (Health, Outreach, Shelter, Transitions) 1143 Liberty St NE, Salem, OR 97301 **16 beds**	–	–	–	✓	–	–	✓	–	Adults only

Sable House

1 program · **10 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Sable House 314 SE Oak St. Dallas, OR 97338 (Advocacy Office, Mailing Address is different) **10 beds**	✓	–	–	–	–	–	–	–	DV survivors

Sheltering Silverton

1 program · **22 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Sheltering Silverton 830B McClaine St. Silverton, OR 97381 **22 beds**	✓	✓	✓	–	–	–	✓	✓	Families

St. Francis Family Housing

1 program · **19 households**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
St. Francis Family Housing 1820 Berry St, Salem, OR 97302 **19 households**	–	–	–	✓	–	–	–	–	Families

United Way Mid-Willamette Valley

1 program · **50 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
SafeSleep United Women's Shelter 1910 NE Front St. NE, Salem, Oregon 97301 **50 beds**	✓	✓	–	✓	–	–	–	–	Families

VETcare Westcare Oregon

1 program · **30 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
VETCare Veterans Home (transitional housing) 2933 NE Center St., Salem, OR 97301 **30 beds**	–	–	–	✓	–	✓	–	–	Adults only

Women at the Well Grace House

1 program · **8 beds**

Program, address, capacity	Emerg	Low-barrier	Warm/cool	Trans	PSH	Recov	Day	Rapid	Populations served
Women at the Well Grace House 1243 SE Peace St. Salem, OR 97302 **8 beds**	–	–	–	✓	–	–	–	–	Adults only

Note: ✓ Service offered – Not offered Emerg. = emergency shelter, Trans. = transitional, PSH = permanent supportive housing, Recov. = recovery, Day = day center, Rapid = rapid re-housing

2026 Needs Assessment of Homelessness and Housing Stability

Appendices

Survey instruments, discussion guides, and detailed survey toplines

PREPARED FOR

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PREPARED BY

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September 2026

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Appendix A. Community Member Survey Instrument

Sixty-three items in eleven sections, hosted on SurveyMonkey with skip logic. Items are numbered to match the detailed toplines in Appendix F. Respondents could skip any question. Consent, eligibility screening, mode routing, and the closing contact and incentive block preceded and followed the items below. Question wording and response options are taken from the survey toplines, which reproduce them as written in the survey with dashes rendered as commas. Response options appear beneath each item. A circle (○) marks a single-choice item and a square (□) marks a select-all item. Bracketed text before an item names who was asked it.

Section A. Current Housing Situation

1. What best describes your current housing and living situation? Think about where you sleep most nights.

- ○ I sleep outside (streets, parks, encampments, vehicle, etc.)
- ○ I stay in an emergency shelter (a place where they only allow you to stay for 1 night at a time)
- ○ I stay in a transitional shelter or housing program (a place where you can stay for an extended period of time while you work on finding a permanent home)
- ○ I am temporarily staying with friends or family ("couch surfing")
- ○ I have housing but am at risk of losing it soon
- ○ Other (please describe)

2. *[Asked of respondents who said they sleep outside]* You mentioned that you sleep outside. Where exactly are you most often sleeping?

- ○ On the street, in a doorway, or in a park
- ○ Outdoor encampment or tent community
- ○ In my vehicle (car, RV, van, etc.)
- ○ In an abandoned building or structure
- ○ Other outdoor location

3. *[Asked of respondents who said they sleep outside]* How long have you been sleeping in this specific location?

- ○ Less than 1 week
- ○ 1–4 weeks
- ○ 1–3 months
- ○ 4–6 months
- ○ 7–11 months
- ○ 12 months (1 year)
- ○ more than 1 year

4. *[Asked of respondents who did not say they sleep outside]* How long have you been in your current housing situation?

- ○ Less than 1 week
- ○ 1–4 weeks
- ○ 1–3 months
- ○ 4–6 months
- ○ 7–11 months
- ○ 12 months (1 year)
- ○ more than 1 year

5. Is this the first time in your life you have experienced homelessness or housing instability?

- ○ Yes, this is my first time
- ○ No, I have experienced homelessness or housing instability before
- ○ Prefer not to answer

6. *[Asked of respondents with a prior experience of homelessness or housing instability]* In the LAST 3 YEARS, approximately how many separate times have you experienced homelessness (counting this time)?

- ○ 2 times
- ○ 3 times
- ○ 4 or more times

7. *[Asked of respondents with a prior experience of homelessness or housing instability]* In total across all those times, approximately how many months have you spent homeless in the last 3 years?

- ○ Less than 6 months total
- ○ 6–11 months total
- ○ 12 months or more total

Section B. Health and Safety

8. Do you have a long-term physical or mental health condition that affects your daily life?

- ○ Yes, physical health condition
- ○ Yes, mental health condition
- ○ Yes, both physical and mental condition
- ○ No
- ○ Prefer not to answer

9. Do you currently feel safe where you are staying?

- ○ Yes, I feel safe
- ○ Somewhat, I have some concerns
- ○ No, I do not feel safe where I am staying
- ○ Prefer not to answer

10. Which of the following concerns or conditions make you feel unsafe? *Check all that apply:*

- □ I don't feel safe around people (violence, threats, or fighting)
- □ Doors or windows that don't lock
- □ Problems inside my home that make it unhealthy (like mold, bugs or mice, or broken heat)
- □ Too many people living in the home
- □ Being treated unfairly or harassed because of who I am
- □ My neighborhood feels unsafe
- □ Something else (please describe)

11. Where are you currently spending most of your time during the day?

- ○ Park
- ○ Day centers
- ○ Library
- ○ Another location (please specify)

Section C. Household

12. How many adults are currently in your household, including yourself?

- ○ Just me (1 person)
- ○ 2 adults
- ○ 3–4 adults
- ○ 5 or more people

13. Do you have children under age 18 who are with you or in your care?

- ○ Yes, children are with me now
- ○ Yes, but my children are not with me right now
- ○ No
- ○ Prefer not to answer

14. *[Asked of respondents whose children are with them now]* You mentioned you have children with you now. How many children are with you now?

- ○ 1 child
- ○ 2 children
- ○ 3 children
- ○ 4 children

15. What are the ages of your children?

Open text

16. Are you currently pregnant or expecting a child?

- ○ Yes
- ○ No
- ○ Prefer not to answer

17. Do you have a pet that makes it harder to find a place to stay or get housing?

- ○ Yes, I have a pet, and it does make it harder to find housing
- ○ Yes, I have a pet, but it does not make it harder to find housing
- ○ No, I do not have a pet

Section D. Place and Connection

18. What is the name of the city or town you currently live in?

- ○ Salem
- ○ Silverton
- ○ Keizer
- ○ Stayton
- ○ Monmouth
- ○ Mill City
- ○ Independence
- ○ Falls City
- ○ Woodburn
- ○ Mt. Angel
- ○ Gervais
- ○ Dallas
- ○ Aurora
- ○ Other

19. How long have you lived in this area?

- ○ Less than 6 months
- ○ 6 months to 1 year
- ○ 1–3 years
- ○ 4–10 years
- ○ More than 10 years
- ○ I grew up here

20. *[Not asked of respondents who said they grew up here]* What brought you to this area?

- □ Family or loved ones are here
- □ I was already living here when I lost my housing
- □ I came for work or a job opportunity
- □ I heard there were more services or resources here
- □ I was referred or transported here by another agency
- □ I was discharged from a hospital, jail, or facility in this area
- □ I was fleeing an unsafe or dangerous situation
- □ I came for a relationship that has since ended
- □ Cost of living seemed more affordable here than where I was
- □ This is where sheltering and other services are located
- □ Other (please specify)

21. *[Not asked of respondents who said they grew up here]* Where did you live before coming to this area?

- ○ Somewhere else in Marion or Polk County
- ○ Another county in Oregon
- ○ Another state
- ○ Another country
- ○ I have moved around frequently with no clear previous home
- ○ I have always lived here

22. If you moved from another county, state, or country, where did you come from?

Open text

23. Do you have family, close friends, or other support people in this area?

- ○ Yes, I have strong connections here
- ○ Yes, some connections but not very close
- ○ I had connections here but they are no longer available
- ○ No, I do not have connections here

24. Where do you feel most at home? This could be where your family or friends are, where you used to live, or a place that just feels like home to you.

- ○ Salem
- ○ Keizer
- ○ Stayton
- ○ Silverton
- ○ Mill City
- ○ Falls City
- ○ Mt. Angel
- ○ Gervais
- ○ Monmouth
- ○ Donald
- ○ Aumsville
- ○ Dallas
- ○ Another place
- ○ I don't really feel at home anywhere right now.

25. Where would you ideally like to live, if you could choose?

- ○ Here in Marion or Polk County, this is my community
- ○ Elsewhere in Oregon
- ○ In another state, where I have connections
- ○ Other (please describe)

Section E. Path to Losing Housing

26. Before you lost your housing, where were you living?

- ○ Renting an apartment or house on my own
- ○ Renting with roommates
- ○ Living with a partner or spouse
- ○ Living with family
- ○ Owning a home
- ○ I have been homeless or unstably housed for most of my life
- ○ Other (please describe)

27. Before losing your housing, did you have a housing voucher, rental subsidy, or other housing assistance?

- ○ Yes, I had a Section 8 / Housing Choice Voucher
- ○ Yes, I had another type of rental subsidy or housing assistance
- ○ I was on a waiting list for a voucher or subsidy but had not received one yet
- ○ I applied but was denied or removed from the waiting list
- ○ No, I did not have a voucher or subsidy
- ○ I don't know

28. *[Asked of respondents who had a voucher or subsidy]* If you had a voucher or subsidy and lost it, what happened?

- □ I lost my housing and could not use the voucher in time
- □ I was evicted
- □ I could not find a landlord who would accept the voucher
- □ My voucher expired before I found housing
- □ My subsidy was terminated by the housing authority
- □ I left voluntarily
- □ Other (please specify)

29. What was the first thing that happened that started your path to losing housing?

- ○ A relationship ended (divorce, breakup, family conflict)
- ○ I could no longer afford rent
- ○ I had to leave because of domestic violence or an unsafe situation
- ○ I lost my job or my income dropped significantly
- ○ I was evicted
- ○ A mental health crisis
- ○ Substance use
- ○ A serious physical health problem
- ○ A natural disaster or fire
- ○ I aged out of foster care
- ○ I was released from jail, prison, or detention
- ○ Other (please describe)
- ○ It happened gradually, no single event

30. What other factors also contributed to losing your housing? *(Select all that apply)*

- □ Could not afford rent or was priced out
- □ Eviction
- □ Job loss or reduced income
- □ Physical health challenges
- □ Mental health challenges
- □ Substance use
- □ Had to leave because of domestic violence or an unsafe situation
- □ Family breakdown or conflict
- □ Release from jail, prison, or detention
- □ Aging out of foster care
- □ Discharge from hospital or treatment without housing
- □ Discrimination (race, gender, identity, disability, etc.)
- □ Lack of affordable housing in the area
- □ Immigration status
- □ Natural disaster or fire
- □ Other (please specify)

31. Before losing your housing, did you receive any support or services that helped you stay housed?

- ○ Yes, I had support and it helped for a while
- ○ Yes, but the support was not enough to prevent homelessness
- ○ No, I did not receive any support
- ○ I did not know support was available

32. *[Asked of respondents who received support]* What type of support did you receive?

- □ Rental assistance or help paying rent
- □ Help paying utilities
- □ Case management or a housing advocate
- □ Mental health services
- □ Substance use treatment or recovery support
- □ Employment or job training support
- □ Food assistance
- □ Transportation help
- □ Legal help (e.g., eviction prevention)
- □ Healthcare or medical support
- □ Childcare support
- □ Government services
- □ Support from a nonprofit or community organization
- □ Help from a friend or family member
- □ Other

Section F. Experiences with Services and Prevention

33. Since becoming homeless, what services or support have hurt you or made things harder? *(Pick all that apply)*

- □ Nothing has hurt or made things harder
- □ Being turned away from shelter or services
- □ Rules or requirements that felt unfair or impossible to follow
- □ Being treated badly or disrespected by staff
- □ Feeling unsafe in a shelter or program
- □ Losing my belongings during a sweep or eviction
- □ Being separated from my family, partner, or pet
- □ Not getting the right help because of my race, language, or background
- □ Services that were too far away or hard to get to
- □ Being asked questions that felt invasive or unsafe
- □ Having my information shared without my permission
- □ A program or service that made my situation worse
- □ Other

34. Since becoming homeless, what supports or services have made the most positive difference for you?

- □ A specific case manager or outreach worker who helped me
- □ Emergency shelter (a place where they only allow you to stay for 1 night at a time)
- □ Food or meal services
- □ Medical or mental health care
- □ Substance use treatment
- □ Benefits or income assistance
- □ Help getting ID or other documents
- □ Legal help
- □ Peer support from someone with lived experience of homelessness
- □ Family or friends
- □ Faith community
- □ Nothing has made a positive difference yet
- □ Other (please specify)

35. Looking back, what, if anything, do you think could have prevented you from losing your housing?

Open text

Section G. Income and Employment

36. What is your current employment status?

- ○ Working full-time
- ○ Working part-time
- ○ Working occasionally or in temporary jobs
- ○ Not currently working, looking for work
- ○ Not currently working, not looking for work
- ○ Unable to work due to disability or health
- ○ Retired
- ○ Prefer not to answer

37. What are your current sources of income or financial support? *(Select all that apply)*

- □ Wages or salary from a job
- □ Social Security Disability (SSDI)
- □ Supplemental Security Income (SSI)
- □ General Assistance or state cash benefits
- □ Unemployment benefits
- □ SNAP (food stamps)
- □ Veterans benefits
- □ Child support or alimony
- □ Support from family or friends
- □ Informal or cash work
- □ No income at this time
- □ Prefer not to answer
- □ Other (please specify)

38. Approximately how much money do you have coming in per month from all sources?

- ○ Nothing, I have no income right now
- ○ Less than $500 per month
- ○ $500–$999 per month
- ○ $1,000–$1,499 per month
- ○ $1,500–$1,999 per month
- ○ $2,000 or more per month
- ○ Prefer not to answer

39. If you are not currently working, what are the biggest barriers to employment for you?

- □ I cannot work due to a disability or health condition
- □ I do not have stable housing or a safe place to get ready for work
- □ I do not have transportation to get to work
- □ I do not have childcare
- □ I do not have the required ID or documents
- □ I have a criminal record that limits my options
- □ I need more training, education, or skills
- □ I have not been able to find a job that pays enough
- □ I have been applying for jobs but have not been hired
- □ Employment is not a barrier for me right now
- □ Other (please specify)

Section H. Health Care and Service Use

40. Do you currently have health insurance?

- ○ Yes, Oregon Health Plan (Medicaid)
- ○ Yes, Medicare
- ○ Yes, employer or private insurance
- ○ Yes, Veterans Administration (VA) coverage
- ○ No, I do not have health insurance
- ○ I am not sure
- ○ Prefer not to answer

41. In the past 12 months, have you visited an emergency room because you could not get care somewhere else?

- ○ Yes, once
- ○ Yes, 2–3 times
- ○ Yes, 4 or more times
- ○ No
- ○ Prefer not to answer

42. In the past 12 months, which of the following services have you used? *(Select all that apply)*

- □ Emergency shelter (a place where they only allow you to stay for 1 night at a time)
- □ Transitional shelter (a place where you can stay for an extended period of time while you work on finding permanent housing)
- □ Rapid rehousing assistance (program to help you find permanent housing)
- □ Food pantry or meal program
- □ Health or medical care
- □ Mental health services
- □ Substance use treatment
- □ Case management
- □ Employment or job training services
- □ Benefits assistance (SNAP, Medicaid, Social Security, etc.)
- □ Transportation assistance
- □ Child or family services
- □ Domestic violence services
- □ Youth services (if you are under 25)
- □ Legal assistance
- □ Peer support from someone with lived experience
- □ I have not used any services in the past 12 months

43. When you have needed services, how easy has it been to access them?

- ○ Very easy
- ○ Somewhat easy
- ○ Somewhat difficult
- ○ Very difficult
- ○ I have not tried to access services

44. What are the biggest barriers that make it hard to access housing and shelter services? *(Select all that apply)*

- □ I don't know what services are available or how to find them
- □ Services are too far away or hard to get to
- □ I don't have transportation
- □ I was told I don't qualify
- □ Waitlists are too long
- □ I had a bad experience with a provider in the past
- □ I don't feel safe at shelters
- □ Shelters require sobriety and I was unable to meet that requirement
- □ Services are not available in my language
- □ Services do not feel culturally welcoming or appropriate
- □ I cannot bring my pet
- □ I was not allowed to bring a family member or partner
- □ I have an outstanding warrant or criminal history
- □ I do not have required ID or documents
- □ I have a disability that makes access difficult
- □ I prefer to manage on my own
- □ No barrier, I can access services when I need them
- □ Other (please specify)

45. Have you ever been turned away from a shelter or housing program?

- ○ Yes
- ○ No
- ○ I don't know

46. *[Asked of respondents who had been turned away]* What was the main reason you were turned away?

- □ The shelter was full
- □ I did not meet sobriety requirements
- □ I had a criminal history that disqualified me
- □ I had a pet that was not allowed
- □ I was not allowed to bring my partner or family member
- □ I did not have required ID
- □ I did not meet age requirements
- □ I was told I did not qualify but was not given a reason
- □ Other (please specify)

Section I. Current Needs

47. What are the top three (3) services or supports do you most need right now that you are not getting?

- □ Safe place to sleep
- □ Permanent housing
- □ Help paying rent or a security deposit
- □ Mental health services
- □ Substance use treatment
- □ Medical or dental care
- □ Food
- □ Income or employment support
- □ Transportation
- □ Help with documents (ID, birth certificate, Social Security card, etc.)
- □ Childcare
- □ Safety from domestic violence
- □ Peer support
- □ Cultural or language-specific services
- □ Health insurance enrollment help
- □ Other (please describe)

48. What type of housing do you most need right now?

- ○ A place of my own with no program requirements attached
- ○ Supported housing where I have my own place and services available
- ○ Transitional housing with structure and support
- ○ Shared housing with others
- ○ Any stable housing, I am not specific about the type
- ○ Other (please describe)

49. In your own words, what would help you most to get or keep stable housing?

Open text

Section J. Service Experiences and Identity

50. Overall, how would you describe your experience with local homeless and housing services?

- ○ Very positive, I feel respected and well-supported
- ○ Mostly positive, helpful with room for improvement
- ○ Mixed, some positive and some negative experiences
- ○ Mostly negative, services have not been helpful or welcoming
- ○ Very negative, I have had serious problems
- ○ I have not used services

51. Do you feel that services are welcoming for people of your background or identity?

- ○ Yes, services feel welcoming and appropriate
- ○ Somewhat, some services feel appropriate but not all
- ○ No, services often do not feel welcoming or appropriate for me
- ○ Not sure

52. Have you ever been turned away from or denied services because of your gender identity, sexual orientation, or a disability?

- ○ Yes, because of my gender identity or sexual orientation
- ○ Yes, because of a disability or health condition
- ○ Yes, both
- ○ No
- ○ I'm not sure
- ○ Prefer not to answer

53. What happened where you have been turned away from services because of your identity:

Open text

54. Have you ever received support from a peer support specialist, someone with their own lived experience of homelessness who helps others?

- ○ Yes, and it was very helpful
- ○ Yes, but it was not particularly helpful
- ○ No, but I would like this kind of support
- ○ No, I am not interested in this type of support
- ○ I am not sure what peer support is

Section K. Demographics and Access

55. How would you describe your gender?

- □ Man
- □ Woman
- □ Non-binary
- □ Transgender
- □ A gender not listed above
- □ Gender non-conforming or genderqueer
- □ Prefer not to answer
- □ Prefer to self-describe (please specify)

56. Do you identify as lesbian, gay, bisexual, queer, or another sexual orientation other than straight or heterosexual?

- ○ Yes
- ○ No
- ○ Questioning or not sure
- ○ Prefer not to answer

57. How old are you?

- ○ 17 years old or younger
- ○ 18–24
- ○ 25–34
- ○ 35–44
- ○ 45–54
- ○ 55–64
- ○ 65 or older
- ○ Prefer not to answer

58. How do you identify your race or ethnicity? *(Select all that apply)*

- □ American Indian or Alaska Native
- □ Asian or Asian American
- □ Black or African American
- □ Hispanic or Latino/a/e/x
- □ Middle Eastern or North African
- □ Native Hawaiian or other Pacific Islander
- □ White
- □ Prefer not to answer
- □ Prefer to self-describe (please specify)

59. What is your preferred language?

- ○ English
- ○ Spanish
- ○ Other

60. Do you identify as a veteran of the U.S. military?

- ○ Yes
- ○ No
- ○ Prefer not to answer

61. Do you currently have a working cell phone?

- ○ Yes, I have a phone with minutes or data
- ○ Yes, but minutes or data are very limited
- ○ No, I do not currently have a working phone

62. Do you have regular access to the internet?

- ○ Yes, on my phone
- ○ Yes, through a library, shelter, or other location
- ○ Rarely, access is very limited
- ○ No

63. Are you be willing to participate in a small group discussion to talk more about your experience?

- ○ Yes
- ○ No

Closing block: contact capture for the incentive and follow-up, and duplicate-prevention fields (first initial, last name, date of birth) used solely to identify repeat submissions and stripped from the analysis dataset.

Appendix B. Service Provider Survey Instrument

Fifty-three items in twelve sections, administered online through a single SurveyMonkey collector with an embedded arithmetic attention check, an optional incentive, and an optional invitation to a follow-up group discussion. Items are numbered to match the detailed toplines in Appendix G. Consent, verification, incentive, and contact questions are not shown. Question wording and response options are taken from the survey toplines, which reproduce them as written in the survey with dashes rendered as commas. Response options appear beneath each item. A circle (○) marks a single-choice item and a square (□) marks a select-all item. Bracketed text before an item names who was asked it.

Section A. Respondents and Organizations

1. What is the name of your organization?

Open text

2. Which best describes your role in this organization?

- ○ Executive Director
- ○ Program Director/ Manager
- ○ Case Manager or Housing Navigator
- ○ Outreach Worker
- ○ Direct services / frontline staff
- ○ Other (please describe)

3. Does your organization have capacity to provide interpreter or translation services for clients who speak a language other than English?

- ○ Yes, we have an in-house interpreter on staff
- ○ Yes, we have contracted or on-call interpreters
- ○ Yes, we provide telephone or remote interpretation
- ○ Yes, we have limited and informal arrangements such as bilingual staff, family, etc.
- ○ No, we do not have interpreter capacity

Section B. Demand, Capacity, and Populations Served

4. In the past 12 months, how has demand for your services changed?

- ○ Demand has significantly increased
- ○ Demand has somewhat increased
- ○ Demand has stayed about the same
- ○ Demand has somewhat decreased

5. Is your organization currently meeting the demand for your services?

- ○ Yes, we are fully meeting the demand for our services.
- ○ We are mostly meeting demand with some gaps.
- ○ The demand for our services exceeds our capacity

6. Does your organization currently have a waitlist?

- ○ Yes
- ○ Sometimes, depending on capacity
- ○ No

7. *[Asked of respondents whose organization has a waitlist all or some of the time]* What is the current wait time?

Open text

8. In the past 12 months, where did most clients go when they exited your program? *(Select all that apply)*

- □ Permanent housing (rental, owned, subsidized)
- □ Permanent supportive housing
- □ Transitional housing or another program
- □ Back to streets, encampments, or vehicles
- □ Emergency shelter
- □ Staying with family or friends
- □ Institutional setting (housing, jail, treatment facility, etc.)
- □ I do not know. We do not systematically track exit destinations.
- □ Other (please describe)

9. What are the biggest staffing challenges your organization faces? *(Select all that apply)*

- □ Wages are not competitive with other employers
- □ High burnout and secondary trauma among staff
- □ Difficulty finding employees who meet the required qualifications
- □ Difficulty recruiting and retaining staff with lived experience of homelessness
- □ Difficulty retaining bilingual or multilingual staff
- □ Lack of affordable housing for staff in the region
- □ Funding does not cover adequate staffing levels
- □ Insufficient training and professional development resources
- □ None. Staffing is not a significant challenge for us right now
- □ Other (please describe)

10. What are the most common needs you observe among the people you serve? *(Select all that apply)*

- □ Emergency shelter beds
- □ Transitional housing
- □ Permanent affordable housing
- □ Rapid rehousing / rental assistance
- □ Mental health services
- □ Substance use treatment
- □ Dual diagnosis support
- □ Physical health or medical care
- □ Health insurance enrollment
- □ Income supports / benefits
- □ Employment or job training
- □ Transportation
- □ Childcare
- □ Culturally specific or language services
- □ Services for justice-involved individuals
- □ Services for LGBTQ+ individuals
- □ Peer support or lived-experience services
- □ Other (please describe)

11. Does your organization try to hire people who have been homeless before?

- ○ Yes, we actively prioritize hiring people who have experienced homelessness
- ○ Yes, we consider it a positive factor but do not prioritize it
- ○ We would like to but face barriers (eg., funding, HR policies, etc.)
- ○ No, we do not have a specific lived experience hiring practice
- ○ I do not know

12. Which populations does your organization primarily serve? *(Select all that apply)*

- □ Single women without children
- □ Single men without children
- □ Single men with children
- □ Single women with children
- □ Couples without children
- □ Couples with children
- □ Youth and young adults (under 25)
- □ Older adults (55+)
- □ Veterans
- □ People with chronic health conditions or disabilities
- □ People with behavioral health or mental health challenges
- □ People with substance use disorders
- □ Latinx / Hispanic community members
- □ Indigenous or Native American community members
- □ LGBTQ+ individuals
- □ Justice-involved individuals (reentry)
- □ Survivors of domestic violence
- □ Farmworkers or agricultural workers
- □ Other (please describe)

Section C. Outcome Data and Racial Equity Review

13. Have you been part of conversations within your organization where you reviewed data to see whether clients of different racial or ethnic backgrounds experience different outcomes, such as different rates of housing placement or program exit?

- ○ Yes, we have reviewed outcomes data and looked at trends by race and ethnicity
- ○ We have looked at the data but have not had a discussion about trends based on client demographics
- ○ No, we have not examined our data to look at trends by outcomes or by demograhic characteristics
- ○ We do not have adequate data to do this analysis
- ○ I don't know/ I don't recall

14. If you have looked at the data, what did you find or notice?

Open text

15. In your role, do you track and record data on client outcomes such as housing placement rates or returns to homelessness?

- ○ Yes, I track and record data on client outcomes regularly
- ○ Yes, I track and record data on client outcomes sometimes
- ○ No, I do not currently track data on client outcomes

16. *[Asked of respondents who track client outcome data]* When you track and record data on client outcomes, do you include long-term outcomes (e.g., client status 6+ months after program exit)?

- ○ Yes, I track long-term outcomes
- ○ Some, I track long-term outcomes for some clients or programs
- ○ No, I only track short-term or point-in-time outcomes

Section D. Tribal Relationships and Indigenous-Specific Services

17. Does your organization have an existing relationship or formal agreement with any federally recognized Tribe or Tribal organization serving Marion or Polk County?

- ○ Yes, we have an active relationship or formal agreement
- ○ Yes, we have had contact but no formal relationship
- ○ No, we have not engaged with Tribal nations or organizations
- ○ I am unsure / not aware of Tribal nations in our service area

18. Please describe the nature of the relationship with any federally recognized Tribe or Tribal organization and describe how it informs your services or referral practices.

Open text

19. Does your organization provide services that are specifically designed for or in partnership with American Indian, Alaska Native, or Indigenous clients?

- ○ Yes
- ○ We are trying to development it.
- ○ No

20. *[Asked of respondents whose organization provides, or is developing, services designed for or with American Indian, Alaska Native, or Indigenous clients]* Briefly describe the types of services you are designing for this population.

Open text

Section E. Client Trends

21. Over the past year, have you seen a shift in the types of households you are serving?

- ○ Yes, we are seeing more families with children
- ○ Yes, we are seeing more youth or young adults on their own
- ○ Yes, we are seeing more older adults (ages 65 and older)
- ○ Yes, we are seeing more single adults
- ○ The mix has stayed roughly the same
- ○ Not sure

22. In your experience, where are the majority of the clients you serve primarily coming from?

- ○ They are from Marion or Polk County, they became homeless here
- ○ They are from other Oregon counties
- ○ They are from other states
- ○ They are from other countries.
- ○ I do not know.

23. What do your clients most commonly share as reasons for their current housing situation? *(Select all that apply)*

- □ Eviction / nonrenewal of lease
- □ Inability to afford rent or housing costs
- □ Job loss or income reduction
- □ Domestic violence / fleeing an unsafe home
- □ Release from jail, prison, or detention without stable housing
- □ Discharge from hospital or treatment program without housing
- □ Aging out of foster care
- □ Mental health crisis
- □ Substance use
- □ Family breakdown or death of a housing provider
- □ Chronic homelessness, long-term pattern
- □ First-time homelessness due to sudden economic shock
- □ Other (please describe)

Section F. Program Requirements, Diversion, and Prevention

24. Does your shelter or housing program have any of the following requirements for entry or continued participation? Select all that apply that your program currently requires.

- □ Sobriety or abstinence from alcohol or drugs
- □ Active participation in substance use treatment
- □ Active participation in mental health treatment
- □ No criminal history or background check approval
- □ Curfew compliance
- □ Participation in program activities or chores
- □ Separation of couples or families
- □ No pets allowed
- □ Gender-segregated programming only
- □ Our program has very few or no restrictive requirements
- □ Not applicable, we are not a shelter or housing program
- □ Other (please specify)

25. If your program has restrictive requirements, what prevents you from becoming a lower-barrier program? *(Select all that apply)*

- □ Funder requirements or grant conditions
- □ Safety or liability concerns for other clients
- □ Staff capacity to support clients with higher needs
- □ Community or neighborhood opposition
- □ Facility limitations (space, physical design)
- □ Board or organizational policy
- □ We are already low-barrier and this is not a constraint
- □ Other (please describe)

26. Does your organization practice housing diversion, actively helping someone avoid shelter entry by connecting them to other options? Diversion might include reconnecting someone with family, short-term financial assistance, mediation, or other alternatives to shelter.

- ○ Yes, diversion is a formal part of our practice
- ○ Yes, informally, we try to divert when possible
- ○ No, but we are interested in implementing diversion
- ○ No, diversion is not appropriate for our program type

27. Does your organization practice housing prevention, helping people remain in housing before they lose it? Prevention includes rental assistance, mediation with landlords, benefits connection, or other supports to avoid eviction or loss of housing.

- ○ Yes, prevention is a core program component
- ○ Yes, we do some prevention work but it is limited
- ○ No, but we would like to expand into prevention
- ○ No, prevention is not our program focus

28. What would most help your organization become more low-barrier or expand diversion and prevention work? *(Select all that apply)*

- □ Flexible funding not tied to restrictive program requirements
- □ Additional staffing or specialized staff (harm reduction workers, peers, etc.)
- □ Technical assistance or training on low-barrier models
- □ Funder policy changes that allow more flexibility
- □ Community education to reduce opposition to low-barrier programs
- □ Shared regional diversion fund accessible to multiple providers
- □ We are already where we need to be on this
- □ I don't know
- □ Other (please describe)

Section G. Harm Reduction

29. Does your organization use harm reduction approaches in your work? Harm reduction meets people where they are, reducing the negative consequences of substance use without requiring abstinence as a condition of service.

- ○ Yes, harm reduction is a core philosophy and formal practice in our work
- ○ Yes, we use some harm reduction practices informally
- ○ We are interested in harm reduction but have not implemented it
- ○ No, our program model requires abstinence or sobriety
- ○ Not applicable to our program type

30. Which of the following harm reduction services or practices does your organization currently offer or connect clients to? *(Select all that apply)*

- □ Naloxone / Narcan distribution and overdose response training
- □ Fentanyl test strip distribution
- □ Syringe services program (SSP) access or referral
- □ Medication-assisted treatment (MAT) linkage, methadone, buprenorphine, etc.
- □ Managed alcohol or safe supply programs
- □ Non-judgmental substance use counseling
- □ Overdose prevention education
- □ Wound care or other health services without sobriety requirements
- □ Peer support from people with lived experience of substance use
- □ We do not currently offer or connect clients to harm reduction services
- □ Other (please describe)

31. What barriers prevent your organization from implementing or expanding harm reduction practices? *(Select all that apply)*

- □ Funder restrictions or grant conditions that prohibit harm reduction
- □ Organizational or board-level opposition
- □ Community or neighborhood opposition
- □ Lack of staff training on harm reduction approaches
- □ Concerns about liability
- □ Lack of community partners or referral resources
- □ Uncertainty about legal status of some harm reduction tools in Oregon
- □ Harm reduction is not a barrier for us, we are where we need to be
- □ I don't know
- □ Other (please describe)

Section H. Coordinated Entry and Regional Coordination

32. Does your organization participate in the local Coordinated Entry system?

- ○ Yes, we are an access point/ we conduct assessments
- ○ Yes, we receive referrals through Coordinated Entry
- ○ Both, we conduct assessments and receive referrals
- ○ We are in the process of connecting to the Coordinated Entry system
- ○ No, we do not currently participate in Coordinated Entry

33. Which vulnerability assessment tool(s) does your organization currently use? *(Select all that apply)*

- □ VI-SPDAT (Vulnerability Index, Service Prioritization Decision Assistance Tool)
- □ TAY-VI-SPDAT (youth version)
- □ Family VI-SPDAT
- □ We use an assessment tool but I am not sure which one
- □ We do not use a standardized vulnerability assessment tool
- □ Other (please specify)

34. How effectively does the Coordinated Entry system match people to appropriate housing and services in this region?

- ○ Very effectively, people are matched to appropriate resources quickly
- ○ Somewhat effectively, the system works but has significant gaps
- ○ Not very effectively, matching is slow or often inappropriate
- ○ Very poorly, the Coordinated Entry system is not functioning well
- ○ I do not have enough visibility into the system to assess this

35. What are the biggest gaps or problems with the current Coordinated Entry system in this region? *(Select all that apply)*

- □ Not enough housing or programs to refer people to, the list is long but resources are short
- □ Prioritization criteria exclude some high-need individuals
- □ The assessment tool may produce biased results for some populations
- □ Access points are not accessible to people in rural areas
- □ The system is not well understood by providers or clients
- □ Inconsistent assessment practices across organizations
- □ Poor communication about referral status and outcomes
- □ Limited capacity for re-assessment when circumstances change
- □ Coordinated Entry is working well, I do not see major problems
- □ I do not know.
- □ Other (please specify)

36. When clients need services your organization doesn't provide, how do you typically connect them to support?

- ○ We maintain an active referral network and regularly connect clients to other organizations
- ○ We make referrals occasionally but do not have a formal process or established relationships
- ○ We provide information about other services but do not make direct referrals
- ○ We do not typically refer clients to other organizations

37. How well do organizations in this region coordinate on homelessness response?

- ○ Very well, coordination is strong and consistent
- ○ Fairly well, some coordination, but gaps remain
- ○ Somewhat, coordination is inconsistent
- ○ Poorly, organizations largely operate in silos
- ○ Very poorly, lack of coordination creates serious problems

38. What are the biggest barriers to effective coordination among providers? *(Select all that apply)*

- □ Lack of shared data systems or formal data sharing agreements
- □ Competing funding requirements that limit collaboration
- □ Organizational or turf conflicts
- □ Inadequate communication structures between agencies
- □ Insufficient staffing or capacity to coordinate
- □ Unclear roles and responsibilities across agencies
- □ Geographic barriers, urban vs. rural
- □ Lack of trust between organizations
- □ Privacy or HIPAA concerns that limit information sharing
- □ Other (please describe)

39. Does your organization have formal data sharing agreements with other agencies? *(Select all that apply)*

- □ Yes, with MWVCAA / ARCHES
- □ Yes, with the local Continuum of Care (CoC)
- □ Yes, with behavioral health or substance use providers
- □ Yes, with Marion or Polk County government
- □ Yes, with hospitals or health systems
- □ Yes, with criminal legal system partners (jails, probation, etc.)
- □ Yes, with other housing or shelter providers
- □ No, we do not have formal data sharing agreements
- □ We are working on establishing data sharing agreements
- □ I do not know.

40. Does your organization have a formal discharge planning process ensuring clients have stable housing or a warm handoff when leaving your program?

- ○ Yes, we have a formal discharge planning protocol
- ○ Yes, but it is inconsistently followed
- ○ Informally, we try to connect clients to next steps but have no formal process
- ○ No, we do not have a discharge planning process
- ○ Not applicable to our program type

Section I. Populations and Access Barriers

41. Which populations do you believe are falling through the cracks in the current system? *(Select all that apply)*

- □ Families with children
- □ Single men
- □ Single women
- □ Single men with children
- □ Single women with children
- □ Youth and young adults (under 25)
- □ Older adults (55+)
- □ People with serious mental illness
- □ People with substance use disorders
- □ People with dual diagnoses
- □ Latinx / Hispanic individuals
- □ Indigenous / Native American individuals
- □ LGBTQ+ individuals
- □ People with disabilities
- □ Veterans
- □ Justice-involved / reentry population
- □ People in rural or outlying areas
- □ Farmworkers or agricultural workers
- □ People without ID or documentation
- □ People with pets
- □ People who do not meet sobriety requirements
- □ Other (please describe)

42. What are the biggest barriers your clients face when trying to access services in general? *(Select all that apply)*

- □ Lack of awareness about available services
- □ Transportation
- □ Long waitlists
- □ Eligibility requirements that exclude people
- □ Lack of services in their language
- □ Safety concerns about shelter environments
- □ Services not welcoming for their identity or culture
- □ Inability to bring pets or partners
- □ Criminal history or outstanding warrants
- □ Lack of ID or documentation
- □ Geographic distance, especially in rural areas
- □ Sobriety requirements
- □ No phone or internet access to find or contact services
- □ Other (please describe)

43. Does your organization employ peer support specialists, staff with their own lived experience of homelessness who work directly with clients? (Select one answer)

- ○ Yes, peer support is a formal part of our workforce
- ○ Yes, we have some peer staff but it is not formalized
- ○ No, but we are interested in adding peer support capacity
- ○ No, peer support is not part of our program model
- ○ I don't know.

Section J. Data Systems and Capacity

44. Which data systems does your organization currently use to manage client and program data? *(Select all that apply)*

- □ HMIS (Homeless Management Information System)
- □ Electronic Health Record (EHR) system
- □ Salesforce or other CRM
- □ Custom internal database
- □ Spreadsheets (Excel, Google Sheets)
- □ Paper records only
- □ We do not systematically track client data
- □ I do not know.
- □ Other (please specify)

45. How complete and reliable is your organization's client data?

- ○ We consistently collect complete, reliable client data across all key fields
- ○ We collect client data but have gaps in some key fields or consistency issues
- ○ We collect some client data but significant gaps limit its usefulness for reporting
- ○ We collect client data but it is not reliable enough for reporting or analysis
- ○ We do not collect client data in a systematic way
- ○ I do not know.

46. What client level data does your organization collect? *(Select all that apply)*

- □ Basic demographics (age, gender, race/ethnicity)
- □ Household composition and family status
- □ Geographic origin/ prior residence
- □ Housing status at intake and exit
- □ Length of time homeless at intake
- □ Income and employment status
- □ Disability status
- □ Veteran status (including discharge status)
- □ Criminal justice involvement
- □ Service utilization history
- □ Housing outcomes (placed, returned to homelessness, etc.)
- □ Client satisfaction or feedback
- □ Racial equity in outcomes (disaggregated outcome data by race)
- □ We do not collect any client data
- □ I don't know

47. Does your organization have staff capacity to analyze your own program data for decision-making?

- ○ Yes, we have dedicated data or evaluation staff
- ○ Somewhat, program or leadership staff do basic analysis
- ○ Limited, we have data but lack capacity to analyze it meaningfully
- ○ No, we do not have data analysis capacity
- ○ I do not know

48. How frequently does your organization use data to inform program decisions or report to funders?

- ○ Regularly, data use is embedded in our decision-making
- ○ Sometimes, we use data for reporting but not consistently for decisions
- ○ Rarely, data is collected but infrequently used
- ○ Not currently, we do not have a data-driven practice
- ○ I do not know.

49. What are the biggest barriers to better data collection and use at your organization? *(Select all that apply)*

- □ Staff capacity, not enough time or expertise
- □ Technology, systems are inadequate or difficult to use
- □ HMIS training and support gaps
- □ Funding, no dedicated resources for data or evaluation
- □ Competing priorities, data is deprioritized under operational demands
- □ Data sharing restriction, privacy or legal barriers
- □ Lack of leadership prioritization of data
- □ We need help knowing what data to collect and why
- □ Data quality, we collect it but can not trust the accuracy
- □ Data is not a significant barrier for us
- □ I do not know.
- □ Other (please specify)

50. What would most help improve data infrastructure and use across the regional homelessness response system?

- □ More HMIS training and technical assistance
- □ Clearer data sharing agreements across agencies
- □ A shared regional data dashboard showing real-time system capacity
- □ Standardized data collection tools and definitions across organizations
- □ A dedicated regional data coordinator or backbone organization
- □ Funding for data and evaluation capacity within organizations
- □ Regular learning convenings where providers review data together
- □ Better connection between CoC data and broader community planning
- □ Training on racial equity analysis of program outcomes
- □ I do not know.
- □ Other (please describe)

Section K. System Strengths and Priorities

51. What is working well in the current homelessness response system that should be protected and expanded?

Open text

52. What is the single most important change that would improve outcomes for people experiencing homelessness in this region?

Open text

Section L. Participation

53. Would you be willing to participate in a future small group discussion as part of the larger community needs assessment?

- ○ Yes
- ○ No

Closing block: contact capture and optional $15 digital gift card, which respondents could decline.

Appendix C. Community Listening Session Protocol and Discussion Guide

C.1 Opening and Consent

Each session opened with the following elements, delivered verbally and, in the Spanish-language session, through an interpreter: there are no right or wrong answers, and we are not looking for anything in particular you should say. The conversation is confidential; notes are taken; nothing will be used to identify you. Participation is voluntary; you may skip any question, take a break, or leave. One person speaks at a time; speak from your own experience; respect different perspectives; do not share what others say outside the room. Recording is taking place, with two devices, so that participants' words are captured accurately. The findings go to the Mid-Willamette Valley Community Action Agency to inform how services are funded and placed. Compensation of $75 in cash is provided in appreciation, plus $20 for completing the companion survey; neither is conditional on what you say.

C.2 Mapping Your Journey: The Five Stations

Station	Prompt	What it surfaces
1. Starting Square	Chosen name or initials, time in the area, the first year of housing loss marked on a timeline, and who is with you on this journey	Entry point, duration, household composition, and who counts as family
2. The First Chute	The moment or event that first caused you to experience homelessness	The initiating event, in the participant's own causal framing
3. The Board	Chutes and ladders since then, marked along a path, with an X for today	Sequence, compounding, and the relative density of setbacks and supports
4. Rules That Don't Work	One barrier per box: ID requirements, sobriety rules, curfews, waitlists, being turned away	Specific, nameable policy and program barriers
5. Winning the Game	What I need / who could help, and what life looks like a year from now if everything works out	Priorities, perceived agency, and the definition of a good outcome

Participants could complete the packet in writing, draw, use colored sticky notes (red for a setback, green for a support), place notes on a wall, or dictate to the facilitator. Accommodation for participants uncomfortable with writing was offered explicitly in every session.

C.3 Group Discussion Guide

1. Tell us your story: when did you first find yourself without consistent housing, and what started it?
2. What has supported you along the way: people, organizations, programs, systems?
3. What has continued to set you back? Are there rules or policies that keep you stuck?
4. What is it like trying to get help? Do you feel you are treated with respect?
5. What is most needed in this community that does not exist or is not available right now?
6. When you need food, a place to sleep, medical care, a shower, or to charge your phone, how do you decide where to go?
7. What does a day look like for you? How do you decide where to sleep?

8. If you could change one thing about how the system is set up, what would make daily life meaningfully easier?
9. If the people who control the money and make the decisions were in this room, what would you want them to hear directly from you?
10. Where do you want to land? What does your life look like a year from now if everything works out?

Appendix D. Service Provider Discussion Guide

1. Looking at the system as a whole, how well are current services meeting the needs of people experiencing homelessness?
2. What are the primary structural and systemic factors driving homelessness in Marion and Polk Counties right now? Have they changed in the last two to three years?
3. Where do people most commonly fall through the cracks?
4. What does coordination between organizations look like in practice: where does it work, and where does it break down?
5. How is coordinated entry functioning, and how are providers using it in practice?
6. What are your organization's biggest challenges and capacity constraints right now?
7. Where are the people you serve coming from?
8. How well is the system serving people whose homelessness is connected to domestic or intimate partner violence?
9. What is most needed in this community that does not exist right now?
10. What is the one thing you most want this needs assessment to say loudly and clearly to MWVCAA, funders, and policy makers?

Appendix E. Shelter Inventory Instrument (Landscape Scan)

Reproduced verbatim from the landscape scan report. The instrument structured data collection for all 44 verified sheltering programs; the completed inventory and per-program verification records appear in the standalone landscape scan report.

Organization and Population Served

1. How would you characterize the type of shelter that your program provides?
   - Day center
   - Emergency shelter
   - Low-barrier shelter
   - Rapid rehousing
   - Warming/cooling shelter
   - Transitional housing
   - Permanent supportive housing
   - Recovery-focused shelter
   - Something else
2. What services do you offer the individuals served in your shelter?
   - Utility assistance
   - Eviction prevention
   - Rental assistance
   - Recovery services/peer support
   - Housing navigation
   - Community health workers
   - Supportive services
   - Outreach
3. Does your program only serve individuals of a specific gender? If so, which genders does your program serve?
4. What age groups does your program serve? Do you provide services to families with children under 18?
5. Is your organization faith-based? (Y/N) If yes, what is your religious affiliation?
6. Is your program culturally specific? (Y/N) If yes, which racial or ethnic communities does your program primarily serve?
7. Do you serve any other specific populations (e.g., veterans, LGBTQ+ individuals, survivors of domestic violence)?
8. What language(s) are spoken at your location? Do you have bilingual staff/advocates on site? Do you offer interpretation services?
9. What are your operating hours?
10. What is your capacity on a typical night (number of beds available)? Are any of these beds in a congregate setting? How many (if any) of these beds are bunk beds?
11. Is there typically a waitlist for services? (Y/N) If not, how many beds are left unoccupied on a typical night?

12. What is the average operating cost per bed per night (if available)?
13. Approximately how many unique individuals does your program serve in a year?
14. Does your organization use HMIS to track client data? (Y/N)

Eligibility and Access

15. What does your eligibility and intake process look like? Please share any details that apply:
    a. How do people access your services? (e.g., walk-in, online form, referral)
    b. Are pets allowed? If so, are there any restrictions on type or size?
    c. Are children allowed?
    d. Do you have any drug testing or substance use policies?
    e. Is your site ADA accessible?
    f. Are there any other eligibility requirements we should know about?

Outreach and Funding

16. What are the primary ways your shelter or program connects with people experiencing homelessness?
17. What are your top 1-2 primary funding sources?
18. Approximately how much funding does your organization receive from those top sources? (Provide approximate dollar amount)

Appendix F. Community Member Survey Detailed Toplines

This appendix reports the question-by-question toplines from the community member survey. Item numbers match the survey instrument in Appendix A, and question wording and response options appear as written in the survey. Each table reports the count and percentage of respondents who answered that question, and the note beneath each table states its base. For select-all questions, counts are people, not selections, so percentages sum to more than 100. Percentages are rounded to whole numbers.

May 12 to August 12, 2026. Community members in Marion and Polk Counties. **n = 161.**

CURRENT HOUSING SITUATION

1. What best describes your current housing and living situation? Think about where you sleep most nights.

Response category	Count	Percent (n = 161)
I sleep outside (streets, parks, encampments, vehicle, etc.)	43	27%
I stay in an emergency shelter (a place where they only allow you to stay for 1 night at a time)	11	7%
I stay in a transitional shelter or housing program (a place where you can stay for an extended period of time while you work on finding a permanent home)	48	30%
I am temporarily staying with friends or family ("couch surfing")	5	3%
I have housing but am at risk of losing it soon	21	13%
Other (please describe)	33	20%

The base is respondents who answered (n = 161).

2. You mentioned that you sleep outside. Where exactly are you most often sleeping?

Response category	Count	Percent (n = 43)
On the street, in a doorway, or in a park	9	21%
Outdoor encampment or tent community	18	42%
In my vehicle (car, RV, van, etc.)	8	19%
In an abandoned building or structure	1	2%
Other outdoor location	7	16%

The base is respondents who answered (n = 43). Asked of respondents who said they sleep outside.

3. How long have you been sleeping in this specific location?

Response category	Count	Percent (n = 43)
Less than 1 week	3	7%
1–4 weeks	6	14%
1–3 months	9	21%
4–6 months	5	12%
7–11 months	4	9%
12 months (1 year)	4	9%
more than 1 year	12	28%

The base is respondents who answered (n = 43). Asked of respondents who said they sleep outside.

4. How long have you been in your current housing situation?

Response category	Count	Percent (n = 118)
Less than 1 week	6	5%
1–4 weeks	10	8%
1–3 months	24	20%
4–6 months	18	15%
7–11 months	8	7%
12 months (1 year)	7	6%
more than 1 year	45	38%

The base is respondents who answered (n = 118). Asked of respondents who did not say they sleep outside.

5. Is this the first time in your life you have experienced homelessness or housing instability?

Response category	Count	Percent (n = 161)
Yes, this is my first time	51	32%
No, I have experienced homelessness or housing instability before	103	64%
Prefer not to answer	7	4%

The base is respondents who answered (n = 161).

6. In the LAST 3 YEARS, approximately how many separate times have you experienced homelessness (counting this time)?

Response category	Count	Percent (n = 103)
2 times	53	51%
3 times	17	17%
4 or more times	33	32%

The base is respondents who answered (n = 103). Asked of respondents with a prior experience of homelessness or housing instability.

7. In total across all those times, approximately how many months have you spent homeless in the last 3 years?

Response category	Count	Percent (n = 103)
Less than 6 months total	22	21%
6–11 months total	13	13%
12 months or more total	68	66%

The base is respondents who answered (n = 103). Asked of respondents with a prior experience of homelessness or housing instability.

HEALTH AND SAFETY

8. Do you have a long-term physical or mental health condition that affects your daily life?

Response category	Count	Percent (n = 161)
Yes, physical health condition	24	15%
Yes, mental health condition	38	24%
Yes, both physical and mental condition	46	29%
No	37	23%
Prefer not to answer	16	10%

The base is respondents who answered (n = 161).

9. Do you currently feel safe where you are staying?

Response category	Count	Percent (n = 161)
Yes, I feel safe	80	50%
Somewhat, I have some concerns	57	35%
No, I do not feel safe where I am staying	20	12%
Prefer not to answer	4	2%

The base is respondents who answered (n = 161).

10. Which of the following concerns or conditions make you feel unsafe? Check all that apply:

Response category	Count	Percent (n = 78)
I don't feel safe around people (violence, threats, or fighting)	47	60%
Doors or windows that don't lock	15	19%
Problems inside my home that make it unhealthy (like mold, bugs or mice, or broken heat)	17	22%
Too many people living in the home	8	10%
Being treated unfairly or harassed because of who I am	27	35%
My neighborhood feels unsafe	23	29%
Something else (please describe)	17	22%

Select all that apply. The base is respondents who selected at least one option (n = 78). Counts are people, not selections, so percentages sum to more than 100. Answered by the 77 respondents who said they feel somewhat safe or not safe, plus one respondent who said they feel safe.

11. Where are you currently spending most of your time during the day?

Response category	Count	Percent (n = 161)
Park	38	24%
Day centers	32	20%
Library	8	5%
Another location (please specify)	83	52%

The base is respondents who answered (n = 161). Write-in locations for "Another location" are not coded in this topline.

HOUSEHOLD

12. How many adults are currently in your household, including yourself?

Response category	Count	Percent (n = 161)
Just me (1 person)	89	55%
2 adults	43	27%
3–4 adults	13	8%
5 or more people	16	10%

The base is respondents who answered (n = 161).

13. Do you have children under age 18 who are with you or in your care?

Response category	Count	Percent (n = 161)
Yes, children are with me now	25	16%
Yes, but my children are not with me right now	15	9%
No	118	73%
Prefer not to answer	3	2%

The base is respondents who answered (n = 161).

14. You mentioned you have children with you now. How many children are with you now?

Response category	Count	Percent (n = 25)
1 child	12	48%
2 children	9	36%
3 children	2	8%
4 children	2	8%

The base is respondents who answered (n = 25). Asked of respondents whose children are with them now.

15. What are the ages of your children? [Open-ended, coded]

Response category	Count	Percent (n = 25)
At least one child under 5	9	36%
At least one child aged 5 to 12	14	56%
At least one child aged 13 to 17	12	48%

Open-ended; ages were read from each written response. The base is respondents who answered (n = 25). A respondent can have children in more than one age group, so percentages sum to more than 100. Respondents listed 44 children in total, ages 2 to 17.

16. Are you currently pregnant or expecting a child?

Response category	Count	Percent (n = 161)
Yes	4	2%
No	156	97%
Prefer not to answer	1	1%

The base is respondents who answered (n = 161).

17. Do you have a pet that makes it harder to find a place to stay or get housing?

Response category	Count	Percent (n = 161)
Yes, I have a pet, and it does make it harder to find housing	40	25%
Yes, I have a pet, but it does not make it harder to find housing	30	19%
No, I do not have a pet	91	57%

The base is respondents who answered (n = 161).

PLACE AND CONNECTION

18. What is the name of the city or town you currently live in?

Response category	Count	Percent (n = 161)
Salem	122	76%
Silverton	7	4%
Keizer	6	4%
Stayton	6	4%
Monmouth	5	3%
Mill City	2	1%
Independence	2	1%
Falls City	2	1%
Woodburn	2	1%
Mt. Angel	1	1%
Gervais	1	1%
Dallas	1	1%
Aurora	1	1%
Other	3	2%

The base is respondents who answered (n = 161). Reported as entered. One respondent chose Other and wrote in Salem, and one wrote in Newberg, which is outside Marion and Polk Counties.

19. How long have you lived in this area?

Response category	Count	Percent (n = 161)
Less than 6 months	29	18%
6 months to 1 year	14	9%
1–3 years	19	12%
4–10 years	31	19%
More than 10 years	32	20%
I grew up here	36	22%

The base is respondents who answered (n = 161).

20. What brought you to this area?

Response category	Count	Percent (n = 125)
Family or loved ones are here	50	40%
I was already living here when I lost my housing	25	20%
I came for work or a job opportunity	16	13%
I heard there were more services or resources here	11	9%
I was referred or transported here by another agency	2	2%
I was discharged from a hospital, jail, or facility in this area	3	2%
I was fleeing an unsafe or dangerous situation	22	18%
I came for a relationship that has since ended	14	11%
Cost of living seemed more affordable here than where I was	5	4%
This is where sheltering and other services are located	18	14%
Other (please specify)	14	11%

Select all that apply. The base is respondents who selected at least one option (n = 125). Counts are people, not selections, so percentages sum to more than 100. Not asked of respondents who said they grew up here.

21. Where did you live before coming to this area?

Response category	Count	Percent (n = 125)
Somewhere else in Marion or Polk County	36	29%
Another county in Oregon	45	36%
Another state	31	25%
Another country	3	2%
I have moved around frequently with no clear previous home	3	2%
I have always lived here	7	6%

The base is respondents who answered (n = 125). Not asked of respondents who said they grew up here.

22. If you moved from another county, state, or country, where did you come from? [Open-ended, coded]

Response category	Count	Percent (n = 79)
Within Marion or Polk County (Salem)	1	1%
Another Oregon county	43	54%
Portland metro area (Multnomah, Washington, Clackamas, Columbia counties)	10	13%
Other Willamette Valley (Linn, Lane, Yamhill counties)	12	15%
Oregon Coast	5	6%
Southern Oregon	9	11%
Central and Eastern Oregon	6	8%
Oregon, location not specified	1	1%
Another state	25	32%
Washington State	4	5%
California	7	9%
Other U.S. states	14	18%
"Washington" with no state or county specified	6	8%
Another country	1	1%
Other or unclear	3	4%

Open-ended. Each response was assigned one code. The base is respondents who answered (n = 79). Mill City, which spans the Linn and Marion county line, is coded as Other Willamette Valley. Five responses name only "Washington" and one says "Born in Washington."

23. Do you have family, close friends, or other support people in this area?

Response category	Count	Percent (n = 161)
Yes, I have strong connections here	47	29%
Yes, some connections but not very close	51	32%
I had connections here but they are no longer available	27	17%
No, I do not have connections here	36	22%

The base is respondents who answered (n = 161).

24. Where do you feel most at home? This could be where your family or friends are, where you used to live, or a place that just feels like home to you.

Response category	Count	Percent (n = 161)
Salem	71	44%
Keizer	7	4%
Stayton	7	4%
Silverton	5	3%
Mill City	5	3%
Falls City	3	2%
Mt. Angel	2	1%
Gervais	2	1%
Monmouth	2	1%
Donald	1	1%
Aumsville	1	1%
Dallas	1	1%
Another place	23	14%
I don't really feel at home anywhere right now.	31	19%

The base is respondents who answered (n = 161). Write-in places for "Another place" are not coded in this topline.

25. Where would you ideally like to live, if you could choose?

Response category	Count	Percent (n = 161)
Here in Marion or Polk County, this is my community	83	52%
Elsewhere in Oregon	33	20%
In another state, where I have connections	19	12%
Other (please describe)	26	16%

The base is respondents who answered (n = 161).

PATH TO LOSING HOUSING

26. Before you lost your housing, where were you living?

Response category	Count	Percent (n = 161)
Renting an apartment or house on my own	55	34%
Renting with roommates	12	7%
Living with a partner or spouse	25	16%
Living with family	35	22%
Owning a home	6	4%
I have been homeless or unstably housed for most of my life	13	8%
Other (please describe)	15	9%

The base is respondents who answered (n = 161).

27. Before losing your housing, did you have a housing voucher, rental subsidy, or other housing assistance?

Response category	Count	Percent (n = 161)
Yes, I had a Section 8 / Housing Choice Voucher	14	9%
Yes, I had another type of rental subsidy or housing assistance	6	4%
I was on a waiting list for a voucher or subsidy but had not received one yet	15	9%
I applied but was denied or removed from the waiting list	2	1%
No, I did not have a voucher or subsidy	108	67%
I don't know	16	10%

The base is respondents who answered (n = 161).

28. If you had a voucher or subsidy and lost it, what happened?

Response category	Count	Percent (n = 20)
I lost my housing and could not use the voucher in time	0	0%
I was evicted	3	15%
I could not find a landlord who would accept the voucher	0	0%
My voucher expired before I found housing	3	15%
My subsidy was terminated by the housing authority	4	20%
I left voluntarily	4	20%
Other (please specify)	8	40%

Select all that apply. The base is respondents who selected at least one option (n = 20). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%. Asked of respondents who had a voucher or subsidy.

29. What was the first thing that happened that started your path to losing housing?

Response category	Count	Percent (n = 161)
A relationship ended (divorce, breakup, family conflict)	25	16%
I could no longer afford rent	21	13%
I had to leave because of domestic violence or an unsafe situation	20	12%
I lost my job or my income dropped significantly	17	11%
I was evicted	11	7%
A mental health crisis	10	6%
Substance use	8	5%
A serious physical health problem	4	2%
A natural disaster or fire	1	1%
I aged out of foster care	1	1%
I was released from jail, prison, or detention	1	1%
Other (please describe)	32	20%
It happened gradually, no single event	10	6%

The base is respondents who answered (n = 161).

30. What other factors also contributed to losing your housing? (Select all that apply)

Response category	Count	Percent (n = 160)
Could not afford rent or was priced out	61	38%
Eviction	24	15%
Job loss or reduced income	48	30%
Physical health challenges	30	19%
Mental health challenges	52	33%
Substance use	29	18%
Had to leave because of domestic violence or an unsafe situation	27	17%
Family breakdown or conflict	48	30%
Release from jail, prison, or detention	9	6%
Aging out of foster care	2	1%
Discharge from hospital or treatment without housing	2	1%
Discrimination (race, gender, identity, disability, etc.)	11	7%
Lack of affordable housing in the area	32	20%
Immigration status	0	0%
Natural disaster or fire	5	3%
Other (please specify)	22	14%

Select all that apply. The base is respondents who selected at least one option (n = 160). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%.

31. Before losing your housing, did you receive any support or services that helped you stay housed?

Response category	Count	Percent (n = 161)
Yes, I had support and it helped for a while	30	19%
Yes, but the support was not enough to prevent homelessness	20	12%
No, I did not receive any support	98	61%
I did not know support was available	13	8%

The base is respondents who answered (n = 161).

32. What type of support did you receive?

Response category	Count	Percent (n = 50)
Rental assistance or help paying rent	20	40%
Help paying utilities	9	18%
Case management or a housing advocate	3	6%
Mental health services	12	24%
Substance use treatment or recovery support	8	16%
Employment or job training support	4	8%
Food assistance	32	64%
Transportation help	6	12%
Legal help (e.g., eviction prevention)	2	4%
Healthcare or medical support	10	20%
Childcare support	1	2%
Government services	4	8%
Support from a nonprofit or community organization	6	12%
Help from a friend or family member	19	38%
Other	3	6%

Select all that apply. The base is respondents who selected at least one option (n = 50). Counts are people, not selections, so percentages sum to more than 100. Asked of respondents who received support.

EXPERIENCES WITH SERVICES AND PREVENTION

33. Since becoming homeless, what services or support have hurt you or made things harder? (Pick all that apply)

Response category	Count	Percent (n = 160)
Nothing has hurt or made things harder	16	10%
Being turned away from shelter or services	49	31%
Rules or requirements that felt unfair or impossible to follow	49	31%
Being treated badly or disrespected by staff	44	28%
Feeling unsafe in a shelter or program	34	21%
Losing my belongings during a sweep or eviction	42	26%
Being separated from my family, partner, or pet	55	34%
Not getting the right help because of my race, language, or background	18	11%
Services that were too far away or hard to get to	35	22%
Being asked questions that felt invasive or unsafe	20	13%
Having my information shared without my permission	21	13%
A program or service that made my situation worse	27	17%
Other	24	15%

Select all that apply. The base is respondents who selected at least one option (n = 160). Counts are people, not selections, so percentages sum to more than 100.

34. Since becoming homeless, what supports or services have made the most positive difference for you?

Response category	Count	Percent (n = 160)
A specific case manager or outreach worker who helped me	59	37%
Emergency shelter (a place where they only allow you to stay for 1 night at a time)	20	13%
Food or meal services	73	46%
Medical or mental health care	40	25%
Substance use treatment	22	14%
Benefits or income assistance	28	18%
Help getting ID or other documents	35	22%
Legal help	5	3%
Peer support from someone with lived experience of homelessness	31	19%
Family or friends	42	26%
Faith community	21	13%
Nothing has made a positive difference yet	13	8%
Other (please specify)	14	9%

Select all that apply. The base is respondents who selected at least one option (n = 160). Counts are people, not selections, so percentages sum to more than 100.

35. Looking back, what, if anything, do you think could have prevented you from losing your housing? [Open-ended, coded]

Response category	Count	Percent (n = 157)
Changes in relationships, family, or household	30	19%
Employment, higher income, or benefits	28	18%
Avoiding substance use (own or others') or getting addiction treatment	16	10%
Different personal choices or money management	16	10%
More support or help from people and services	14	9%
Landlord or program practices, or legal help	14	9%
Mental health care, counseling, or less stress	12	8%
Lower rent or more affordable housing	8	5%
Domestic violence, abuse, or an unsafe home	8	5%
Rental or financial assistance, including vouchers	8	5%
Avoiding criminal legal involvement	4	3%
Health care, health, or disability	4	3%
Nothing could have prevented it, or it was out of their control	20	13%
Other	11	7%
No, don't know, or not applicable	15	10%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 157), including responses coded as no answer.

INCOME AND EMPLOYMENT

36. What is your current employment status?

Response category	Count	Percent (n = 161)
Working full-time	23	14%
Working part-time	14	9%
Working occasionally or in temporary jobs	8	5%
Not currently working, looking for work	47	29%
Not currently working, not looking for work	15	9%
Unable to work due to disability or health	40	25%
Retired	6	4%
Prefer not to answer	8	5%

The base is respondents who answered (n = 161).

37. What are your current sources of income or financial support? (Select all that apply)

Response category	Count	Percent (n = 161)
Wages or salary from a job	38	24%
Social Security Disability (SSDI)	12	7%
Supplemental Security Income (SSI)	15	9%
General Assistance or state cash benefits	14	9%
Unemployment benefits	2	1%
SNAP (food stamps)	90	56%
Veterans benefits	2	1%
Child support or alimony	1	1%
Support from family or friends	14	9%
Informal or cash work	11	7%
No income at this time	36	22%
Prefer not to answer	6	4%
Other (please specify)	16	10%

Select all that apply. The base is respondents who selected at least one option (n = 161). Counts are people, not selections, so percentages sum to more than 100.

38. Approximately how much money do you have coming in per month from all sources?

Response category	Count	Percent (n = 161)
Nothing, I have no income right now	58	36%
Less than $500 per month	37	23%
$500–$999 per month	17	11%
$1,000–$1,499 per month	22	14%
$1,500–$1,999 per month	7	4%
$2,000 or more per month	8	5%
Prefer not to answer	12	7%

The base is respondents who answered (n = 161).

39. If you are not currently working, what are the biggest barriers to employment for you?

Response category	Count	Percent (n = 161)
I cannot work due to a disability or health condition	57	35%
I do not have stable housing or a safe place to get ready for work	37	23%
I do not have transportation to get to work	43	27%
I do not have childcare	8	5%
I do not have the required ID or documents	13	8%
I have a criminal record that limits my options	34	21%
I need more training, education, or skills	26	16%
I have not been able to find a job that pays enough	10	6%
I have been applying for jobs but have not been hired	35	22%
Employment is not a barrier for me right now	28	17%
Other (please specify)	19	12%

Select all that apply. The base is respondents who selected at least one option (n = 161). Counts are people, not selections, so percentages sum to more than 100.

HEALTH CARE AND SERVICE USE

40. Do you currently have health insurance?

Response category	Count	Percent (n = 161)
Yes, Oregon Health Plan (Medicaid)	125	78%
Yes, Medicare	8	5%
Yes, employer or private insurance	4	2%
Yes, Veterans Administration (VA) coverage	1	1%
No, I do not have health insurance	12	7%
I am not sure	7	4%
Prefer not to answer	4	2%

The base is respondents who answered (n = 161).

41. In the past 12 months, have you visited an emergency room because you could not get care somewhere else?

Response category	Count	Percent (n = 161)
Yes, once	35	22%
Yes, 2–3 times	22	14%
Yes, 4 or more times	9	6%
No	88	55%
Prefer not to answer	7	4%

The base is respondents who answered (n = 161).

42. In the past 12 months, which of the following services have you used? (Select all that apply)

Response category	Count	Percent (n = 161)
Emergency shelter (a place where they only allow you to stay for 1 night at a time)	29	18%
Transitional shelter (a place where you can stay for an extended period of time while you work on finding permanent housing)	56	35%
Rapid rehousing assistance (program to help you find permanent housing)	10	6%
Food pantry or meal program	89	55%
Health or medical care	67	42%
Mental health services	44	27%
Substance use treatment	26	16%
Case management	42	26%
Employment or job training services	14	9%
Benefits assistance (SNAP, Medicaid, Social Security, etc.)	97	60%
Transportation assistance	39	24%
Child or family services	6	4%
Domestic violence services	8	5%
Youth services (if you are under 25)	4	2%
Legal assistance	12	7%
Peer support from someone with lived experience	28	17%
I have not used any services in the past 12 months	10	6%

Select all that apply. The base is respondents who selected at least one option (n = 161). Counts are people, not selections, so percentages sum to more than 100.

43. When you have needed services, how easy has it been to access them?

Response category	Count	Percent (n = 161)
Very easy	19	12%
Somewhat easy	54	34%
Somewhat difficult	50	31%
Very difficult	30	19%
I have not tried to access services	8	5%

The base is respondents who answered (n = 161).

44. What are the biggest barriers that make it hard to access housing and shelter services? (Select all that apply)

Response category	Count	Percent (n = 161)
I don't know what services are available or how to find them	77	48%
Services are too far away or hard to get to	29	18%
I don't have transportation	49	30%
I was told I don't qualify	36	22%
Waitlists are too long	68	42%
I had a bad experience with a provider in the past	11	7%
I don't feel safe at shelters	27	17%
Shelters require sobriety and I was unable to meet that requirement	9	6%
Services are not available in my language	0	0%
Services do not feel culturally welcoming or appropriate	5	3%
I cannot bring my pet	27	17%
I was not allowed to bring a family member or partner	17	11%
I have an outstanding warrant or criminal history	9	6%
I do not have required ID or documents	11	7%
I have a disability that makes access difficult	17	11%
I prefer to manage on my own	11	7%
No barrier, I can access services when I need them	10	6%
Other (please specify)	12	7%

Select all that apply. The base is respondents who selected at least one option (n = 161). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%.

45. Have you ever been turned away from a shelter or housing program?

Response category	Count	Percent (n = 161)
Yes	73	45%
No	64	40%
I don't know	24	15%

The base is respondents who answered (n = 161).

46. What was the main reason you were turned away?

Response category	Count	Percent (n = 73)
The shelter was full	26	36%
I did not meet sobriety requirements	7	10%
I had a criminal history that disqualified me	9	12%
I had a pet that was not allowed	16	22%
I was not allowed to bring my partner or family member	8	11%
I did not have required ID	6	8%
I did not meet age requirements	2	3%
I was told I did not qualify but was not given a reason	17	23%
Other (please specify)	18	25%

Select all that apply. The base is respondents who selected at least one option (n = 73). Counts are people, not selections, so percentages sum to more than 100. Asked of respondents who had been turned away.

CURRENT NEEDS

47. What are the top three (3) services or supports do you most need right now that you are not getting?

Response category	Count	Percent (n = 159)
Safe place to sleep	31	19%
Permanent housing	95	60%
Help paying rent or a security deposit	61	38%
Mental health services	25	16%
Substance use treatment	5	3%
Medical or dental care	14	9%
Food	43	27%
Income or employment support	43	27%
Transportation	34	21%
Help with documents (ID, birth certificate, Social Security card, etc.)	15	9%
Childcare	6	4%
Safety from domestic violence	4	3%
Peer support	11	7%
Cultural or language-specific services	0	0%
Health insurance enrollment help	3	2%
Other (please describe)	17	11%

Select all that apply. The base is respondents who selected at least one option (n = 159). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%. Respondents were asked to choose up to three.

48. What type of housing do you most need right now?

Response category	Count	Percent (n = 161)
A place of my own with no program requirements attached	53	33%
Supported housing where I have my own place and services available	41	25%
Transitional housing with structure and support	4	2%
Shared housing with others	4	2%
Any stable housing, I am not specific about the type	29	18%
Other (please describe)	30	19%

The base is respondents who answered (n = 161).

49. In your own words, what would help you most to get or keep stable housing? [Open-ended, coded]

Response category	Count	Percent (n = 160)
Employment or better-paying work	36	23%
Affordable or income-based housing	32	20%
Income or disability benefits (SSI, SSDI)	21	13%
Case management, navigation, or supportive people	19	12%
Rent, deposit, or move-in assistance, subsidies, or vouchers	16	10%
Sobriety, recovery, or mental or physical health care	11	7%
Transportation, a vehicle, or a driver's license	9	6%
Housing that allows pets or partners	7	4%
Simpler paperwork or easier access to services	6	4%
Fewer screening barriers (criminal history, credit, rental history)	5	3%
Childcare	4	3%
ID or documents	1	1%
Already housed or no current need	6	4%
Other	19	12%
No, don't know, or not applicable	15	9%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 160), including responses coded as no answer.

SERVICE EXPERIENCES AND IDENTITY

50. Overall, how would you describe your experience with local homeless and housing services?

Response category	Count	Percent (n = 161)
Very positive, I feel respected and well-supported	21	13%
Mostly positive, helpful with room for improvement	27	17%
Mixed, some positive and some negative experiences	67	42%
Mostly negative, services have not been helpful or welcoming	14	9%
Very negative, I have had serious problems	11	7%
I have not used services	21	13%

The base is respondents who answered (n = 161).

51. Do you feel that services are welcoming for people of your background or identity?

Response category	Count	Percent (n = 161)
Yes, services feel welcoming and appropriate	56	35%
Somewhat, some services feel appropriate but not all	58	36%
No, services often do not feel welcoming or appropriate for me	26	16%
Not sure	21	13%

The base is respondents who answered (n = 161).

52. Have you ever been turned away from or denied services because of your gender identity, sexual orientation, or a disability?

Response category	Count	Percent (n = 161)
Yes, because of my gender identity or sexual orientation	6	4%
Yes, because of a disability or health condition	6	4%
Yes, both	9	6%
No	112	70%
I'm not sure	22	14%
Prefer not to answer	6	4%

The base is respondents who answered (n = 161).

53. What happened where you have been turned away from services because of your identity:

[Open-ended, coded]

Response category	Count	Percent (n = 20)
Disability or health condition, including service animals	5	25%
Unfair treatment or denial with no reason stated	4	20%
Race or ethnicity	3	15%
Gender	2	10%
Recovery status	1	5%
Having children or pets, or lacking ID	1	5%
Described a reaction rather than an event	2	10%
No incident described, or not applicable	4	20%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 20), including responses coded as no answer. Small base. Counts describe what respondents wrote and are not rates for the full sample.

54. Have you ever received support from a peer support specialist, someone with their own lived experience of homelessness who helps others?

Response category	Count	Percent (n = 161)
Yes, and it was very helpful	50	31%
Yes, but it was not particularly helpful	15	9%
No, but I would like this kind of support	45	28%
No, I am not interested in this type of support	28	17%
I am not sure what peer support is	23	14%

The base is respondents who answered (n = 161).

55. How would you describe your gender?

Response category	Count	Percent (n = 160)
Man	67	42%
Woman	87	54%
Non-binary	6	4%
Transgender	4	3%
A gender not listed above	0	0%
Gender non-conforming or genderqueer	6	4%
Prefer not to answer	2	1%
Prefer to self-describe (please specify)	3	2%

Select all that apply. The base is respondents who selected at least one option (n = 160). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%.

56. Do you identify as lesbian, gay, bisexual, queer, or another sexual orientation other than straight or heterosexual?

Response category	Count	Percent (n = 160)
Yes	22	14%
No	126	79%
Questioning or not sure	3	2%
Prefer not to answer	9	6%

The base is respondents who answered (n = 160).

57. How old are you?

Response category	Count	Percent (n = 160)
17 years old or younger	4	3%
18–24	22	14%
25–34	29	18%
35–44	41	26%
45–54	32	20%
55–64	19	12%
65 or older	10	6%
Prefer not to answer	3	2%

The base is respondents who answered (n = 160). Reported as entered.

58. How do you identify your race or ethnicity? (Select all that apply)

Response category	Count	Percent (n = 159)
American Indian or Alaska Native	14	9%
Asian or Asian American	0	0%
Black or African American	7	4%
Hispanic or Latino/a/e/x	21	13%
Middle Eastern or North African	1	1%
Native Hawaiian or other Pacific Islander	4	3%
White	122	77%
Prefer not to answer	9	6%
Prefer to self-describe (please specify)	2	1%

Select all that apply. The base is respondents who selected at least one option (n = 159). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%.

59. What is your preferred language?

Response category	Count	Percent (n = 160)
English	158	99%
Spanish	1	1%
Other	1	1%

The base is respondents who answered (n = 160).

60. Do you identify as a veteran of the U.S. military?

Response category	Count	Percent (n = 160)
Yes	6	4%
No	150	94%
Prefer not to answer	4	3%

The base is respondents who answered (n = 160).

61. Do you currently have a working cell phone?

Response category	Count	Percent (n = 160)
Yes, I have a phone with minutes or data	104	65%
Yes, but minutes or data are very limited	27	17%
No, I do not currently have a working phone	29	18%

The base is respondents who answered (n = 160).

62. Do you have regular access to the internet?

Response category	Count	Percent (n = 159)
Yes, on my phone	105	66%
Yes, through a library, shelter, or other location	25	16%
Rarely, access is very limited	13	8%
No	16	10%

The base is respondents who answered (n = 159).

63. Are you be willing to participate in a small group discussion to talk more about your experience?

Response category	Count	Percent (n = 161)
Yes	83	52%
No	78	48%

The base is respondents who answered (n = 161).

Appendix G. Service Provider Survey Detailed Toplines

This appendix reports the question-by-question toplines from the service provider survey. Item numbers match the survey instrument in Appendix B, and question wording and response options appear as written in the survey. Each table reports the count and percentage of respondents who answered that question, and the note beneath each table states its base. For select-all questions, counts are people, not selections, so percentages sum to more than 100. Percentages are rounded to whole numbers.

May 12 to August 12, 2026. Service providers in Marion and Polk Counties. **n = 90.**

RESPONDENTS AND ORGANIZATIONS

1. What is the name of your organization? [Open-ended, coded]

Response category	Count	Percent (n = 90)
MWVCAA, including the ARCHES Project	28	31%
Church at the Park	18	20%
Sheltering Silverton	7	8%
Bridgeway Community Health	6	7%
Northwest Human Services	6	7%
Recovery Outreach Community Center (ROCC)	5	6%
Catholic Community Services	2	2%
Community Wellness and Recovery Living (CRAWL)	2	2%
16 other organizations with one respondent each	16	18%

Open-ended. Written names were standardized (spelling, abbreviations, program names). Respondents named 24 distinct organizations. The base is respondents who answered (n = 90). ARCHES Project write-ins are grouped with MWVCAA.

2. Which best describes your role in this organization?

Response category	Count	Percent (n = 90)
Executive Director	3	3%
Program Director/ Manager	15	17%
Case Manager or Housing Navigator	17	19%
Outreach Worker	10	11%
Direct services / frontline staff	18	20%
Other (please describe)	27	30%

The base is respondents who answered (n = 90). Write-in roles for "Other" are not coded in this topline.

3. Does your organization have capacity to provide interpreter or translation services for clients who speak a language other than English?

Response category	Count	Percent (n = 90)
Yes, we have an in-house interpreter on staff	26	29%
Yes, we have contracted or on-call interpreters	17	19%
Yes, we provide telephone or remote interpretation	8	9%
Yes, we have limited and informal arrangements such as bilingual staff, family, etc.	26	29%
No, we do not have interpreter capacity	13	14%

The base is respondents who answered (n = 90).

DEMAND, CAPACITY, AND POPULATIONS SERVED

4. In the past 12 months, how has demand for your services changed?

Response category	Count	Percent (n = 90)
Demand has significantly increased	47	52%
Demand has somewhat increased	29	32%
Demand has stayed about the same	13	14%
Demand has somewhat decreased	1	1%

The base is respondents who answered (n = 90).

5. Is your organization currently meeting the demand for your services?

Response category	Count	Percent (n = 90)
Yes, we are fully meeting the demand for our services.	13	14%
We are mostly meeting demand with some gaps.	48	53%
The demand for our services exceeds our capacity	29	32%

The base is respondents who answered (n = 90).

6. Does your organization currently have a waitlist?

Response category	Count	Percent (n = 90)
Yes	42	47%
Sometimes, depending on capacity	27	30%
No	21	23%

The base is respondents who answered (n = 90).

7. What is the current wait time? [Open-ended, coded]

Response category	Count	Percent (n = 66)
No wait or same day	5	8%
Up to 2 weeks	11	17%
More than 2 weeks, up to 3 months	7	11%
More than 3 months, up to 1 year	11	17%
More than 1 year	5	8%
Varies by program, client, or capacity (no estimate given)	15	23%
Other (applicant count or scheduling)	2	3%
Don't know	10	15%

Open-ended. Each response was assigned one code. The base is respondents who answered (n = 66). Asked of respondents whose organization has a waitlist all or some of the time. Ranges are coded by the longest time stated.

8. In the past 12 months, where did most clients go when they exited your program? (Select all that apply)

Response category	Count	Percent (n = 90)
Permanent housing (rental, owned, subsidized)	48	53%
Permanent supportive housing	25	28%
Transitional housing or another program	39	43%
Back to streets, encampments, or vehicles	33	37%
Emergency shelter	22	24%
Staying with family or friends	28	31%
Institutional setting (housing, jail, treatment facility, etc.)	12	13%
I do not know. We do not systematically track exit destinations.	14	16%
Other (please describe)	10	11%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

9. What are the biggest staffing challenges your organization faces? (Select all that apply)

Response category	Count	Percent (n = 90)
Wages are not competitive with other employers	27	30%
High burnout and secondary trauma among staff	39	43%
Difficulty finding employees who meet the required qualifications	14	16%
Difficulty recruiting and retaining staff with lived experience of homelessness	12	13%
Difficulty retaining bilingual or multilingual staff	18	20%
Lack of affordable housing for staff in the region	14	16%
Funding does not cover adequate staffing levels	44	49%
Insufficient training and professional development resources	15	17%
None. Staffing is not a significant challenge for us right now	17	19%
Other (please describe)	8	9%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

10. What are the most common needs you observe among the people you serve? (Select all that apply)

Response category	Count	Percent (n = 90)
Emergency shelter beds	59	66%
Transitional housing	51	57%
Permanent affordable housing	71	79%
Rapid rehousing / rental assistance	69	77%
Mental health services	72	80%
Substance use treatment	54	60%
Dual diagnosis support	40	44%
Physical health or medical care	45	50%
Health insurance enrollment	24	27%
Income supports / benefits	55	61%
Employment or job training	56	62%
Transportation	63	70%
Childcare	26	29%
Culturally specific or language services	29	32%
Services for justice-involved individuals	30	33%
Services for LGBTQ+ individuals	19	21%
Peer support or lived-experience services	29	32%
Other (please describe)	4	4%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

11. Does your organization try to hire people who have been homeless before?

Response category	Count	Percent (n = 90)
Yes, we actively prioritize hiring people who have experienced homelessness	21	23%
Yes, we consider it a positive factor but do not prioritize it	41	46%
We would like to but face barriers (eg., funding, HR policies, etc.)	3	3%
No, we do not have a specific lived experience hiring practice	6	7%
I do not know	19	21%

The base is respondents who answered (n = 90).

12. Which populations does your organization primarily serve? (Select all that apply)

Response category	Count	Percent (n = 90)
Single women without children	61	68%
Single men without children	64	71%
Single men with children	50	56%
Single women with children	56	62%
Couples without children	56	62%
Couples with children	54	60%
Youth and young adults (under 25)	48	53%
Older adults (55+)	65	72%
Veterans	51	57%
People with chronic health conditions or disabilities	60	67%
People with behavioral health or mental health challenges	68	76%
People with substance use disorders	65	72%
Latinx / Hispanic community members	44	49%
Indigenous or Native American community members	37	41%
LGBTQ+ individuals	44	49%
Justice-involved individuals (reentry)	40	44%
Survivors of domestic violence	54	60%
Farmworkers or agricultural workers	30	33%
Other (please describe)	8	9%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

OUTCOME DATA AND RACIAL EQUITY REVIEW

13. Have you been part of conversations within your organization where you reviewed data to see whether clients of different racial or ethnic backgrounds experience different outcomes, such as different rates of housing placement or program exit?

Response category	Count	Percent (n = 90)
Yes, we have reviewed outcomes data and looked at trends by race and ethnicity	10	11%
We have looked at the data but have not had a discussion about trends based on client demographics	12	13%
No, we have not examined our data to look at trends by outcomes or by demograhic characteristics	15	17%
We do not have adequate data to do this analysis	7	8%
I don’t know/ I don’t recall	46	51%

The base is respondents who answered (n = 90).

14. If you have looked at the data, what did you find or notice? [Open-ended, coded]

Response category	Count	Percent (n = 21)
Differences in outcomes or barriers by race, ethnicity, or other identity	8	38%
Did not personally review the data	7	33%
Client demographics described or compared with the service area	4	19%
Need or demand exceeds available resources	2	10%
Other	2	10%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 21), including responses coded as no answer. Small base. Several respondents said they had not reviewed the data themselves.

15. In your role, do you track and record data on client outcomes such as housing placement rates or returns to homelessness?

Response category	Count	Percent (n = 90)
Yes, I track and record data on client outcomes regularly	29	32%
Yes, I track and record data on client outcomes sometimes	16	18%
No, I do not currently track data on client outcomes	45	50%

The base is respondents who answered (n = 90).

16. When you track and record data on client outcomes, do you include long-term outcomes (e.g., client status 6+ months after program exit)?

Response category	Count	Percent (n = 45)
Yes, I track long-term outcomes	16	36%
Some, I track long-term outcomes for some clients or programs	11	24%
No, I only track short-term or point-in-time outcomes	18	40%

The base is respondents who answered (n = 45). Asked of respondents who track client outcome data.

TRIBAL RELATIONSHIPS AND INDIGENOUS-SPECIFIC SERVICES

17. Does your organization have an existing relationship or formal agreement with any federally recognized Tribe or Tribal organization serving Marion or Polk County?

Response category	Count	Percent (n = 90)
Yes, we have an active relationship or formal agreement	4	4%
Yes, we have had contact but no formal relationship	15	17%
No, we have not engaged with Tribal nations or organizations	15	17%
I am unsure / not aware of Tribal nations in our service area	56	62%

The base is respondents who answered (n = 90).

18. Please describe the nature of the relationship with any federally recognized Tribe or Tribal organization and describe how it informs your services or referral practices. [Open-ended, coded]

Response category	Count	Percent (n = 17)
Referrals to Tribal or culturally specific services	5	29%
Coordination or case management for shared clients	5	29%
Contact with the Confederated Tribes of Grand Ronde (named)	5	29%
Interest in a stronger or more formal relationship	3	18%
Funding or grant relationship	2	12%
Described as a community partner	2	12%
Staff education or training	1	6%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 17), including responses coded as no answer. Small base.

19. Does your organization provide services that are specifically designed for or in partnership with American Indian, Alaska Native, or Indigenous clients?

Response category	Count	Percent (n = 90)
Yes	12	13%
We are trying to development it.	16	18%
No	62	69%

The base is respondents who answered (n = 90).

20. Briefly describe the types of services you are designing for this population. [Open-ended, coded]

Response category	Count	Percent (n = 28)
Partnering with or referring to Tribal or Native-serving organizations	7	25%
Culturally specific groups, circles, or counselors	4	14%
Recovery, behavioral health, or medical services	3	11%
Basic needs and navigation (meals, showers, laundry, resources)	3	11%
Services open to all, or a general description	3	11%
Housing or rapid rehousing	2	7%
Employment or workforce services	2	7%
Street or community outreach	2	7%
Language access	1	4%
Other	1	4%
Not involved, or don't know	3	11%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 28), including responses coded as no answer. Asked of respondents whose organization provides, or is developing, services designed for or with American Indian, Alaska Native, or Indigenous clients.

CLIENT TRENDS

21. Over the past year, have you seen a shift in the types of households you are serving?

Response category	Count	Percent (n = 90)
Yes, we are seeing more families with children	9	10%
Yes, we are seeing more youth or young adults on their own	7	8%
Yes, we are seeing more older adults (ages 65 and older)	19	21%
Yes, we are seeing more single adults	8	9%
The mix has stayed roughly the same	32	36%
Not sure	15	17%

The base is respondents who answered (n = 90).

22. In your experience, where are the majority of the clients you serve primarily coming from?

Response category	Count	Percent (n = 90)
They are from Marion or Polk County, they became homeless here	76	84%
They are from other Oregon counties	3	3%
They are from other states	2	2%
They are from other countries.	3	3%
I do not know.	6	7%

The base is respondents who answered (n = 90).

23. What do your clients most commonly share as reasons for their current housing situation? (Select all that apply)

Response category	Count	Percent (n = 89)
Eviction / nonrenewal of lease	56	63%
Inability to afford rent or housing costs	78	88%
Job loss or income reduction	59	66%
Domestic violence / fleeing an unsafe home	53	60%
Release from jail, prison, or detention without stable housing	44	49%
Discharge from hospital or treatment program without housing	36	40%
Aging out of foster care	9	10%
Mental health crisis	56	63%
Substance use	65	73%
Family breakdown or death of a housing provider	31	35%
Chronic homelessness, long-term pattern	61	69%
First-time homelessness due to sudden economic shock	49	55%
Other (please describe)	5	6%

Select all that apply. The base is respondents who selected at least one option (n = 89). Counts are people, not selections, so percentages sum to more than 100.

PROGRAM REQUIREMENTS, DIVERSION, AND PREVENTION

24. Does your shelter or housing program have any of the following requirements for entry or continued participation? Select all that apply that your program currently requires.

Response category	Count	Percent (n = 90)
Sobriety or abstinence from alcohol or drugs	14	16%
Active participation in substance use treatment	10	11%
Active participation in mental health treatment	5	6%
No criminal history or background check approval	3	3%
Curfew compliance	29	32%
Participation in program activities or chores	20	22%
Separation of couples or families	2	2%
No pets allowed	11	12%
Gender-segregated programming only	3	3%
Our program has very few or no restrictive requirements	42	47%
Not applicable, we are not a shelter or housing program	23	26%
Other (please specify)	14	16%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

25. If your program has restrictive requirements, what prevents you from becoming a lower-barrier program? (Select all that apply)

Response category	Count	Percent (n = 60)
Funder requirements or grant conditions	17	28%
Safety or liability concerns for other clients	15	25%
Staff capacity to support clients with higher needs	15	25%
Community or neighborhood opposition	2	3%
Facility limitations (space, physical design)	8	13%
Board or organizational policy	6	10%
We are already low-barrier and this is not a constraint	35	58%
Other (please describe)	5	8%

Select all that apply. The base is respondents who selected at least one option (n = 60). Counts are people, not selections, so percentages sum to more than 100.

26. Does your organization practice housing diversion, actively helping someone avoid shelter entry by connecting them to other options? Diversion might include reconnecting someone with family, short-term financial assistance, mediation, or other alternatives to shelter.

Response category	Count	Percent (n = 90)
Yes, diversion is a formal part of our practice	22	24%
Yes, informally, we try to divert when possible	32	36%
No, but we are interested in implementing diversion	10	11%
No, diversion is not appropriate for our program type	26	29%

The base is respondents who answered (n = 90).

27. Does your organization practice housing prevention, helping people remain in housing before they lose it? Prevention includes rental assistance, mediation with landlords, benefits connection, or other supports to avoid eviction or loss of housing.

Response category	Count	Percent (n = 90)
Yes, prevention is a core program component	31	34%
Yes, we do some prevention work but it is limited	30	33%
No, but we would like to expand into prevention	8	9%
No, prevention is not our program focus	21	23%

The base is respondents who answered (n = 90).

28. What would most help your organization become more low-barrier or expand diversion and prevention work? (Select all that apply)

Response category	Count	Percent (n = 90)
Flexible funding not tied to restrictive program requirements	51	57%
Additional staffing or specialized staff (harm reduction workers, peers, etc.)	40	44%
Technical assistance or training on low-barrier models	15	17%
Funder policy changes that allow more flexibility	31	34%
Community education to reduce opposition to low-barrier programs	27	30%
Shared regional diversion fund accessible to multiple providers	18	20%
We are already where we need to be on this	11	12%
I don't know	19	21%
Other (please describe)	3	3%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

HARM REDUCTION

29. Does your organization use harm reduction approaches in your work? Harm reduction meets people where they are, reducing the negative consequences of substance use without requiring abstinence as a condition of service.

Response category	Count	Percent (n = 90)
Yes, harm reduction is a core philosophy and formal practice in our work	47	52%
Yes, we use some harm reduction practices informally	28	31%
We are interested in harm reduction but have not implemented it	3	3%
No, our program model requires abstinence or sobriety	4	4%
Not applicable to our program type	8	9%

The base is respondents who answered (n = 90).

30. Which of the following harm reduction services or practices does your organization currently offer or connect clients to? (Select all that apply)

Response category	Count	Percent (n = 79)
Naloxone / Narcan distribution and overdose response training	56	71%
Fentanyl test strip distribution	21	27%
Syringe services program (SSP) access or referral	3	4%
Medication-assisted treatment (MAT) linkage, methadone, buprenorphine, etc.	18	23%
Managed alcohol or safe supply programs	3	4%
Non-judgmental substance use counseling	19	24%
Overdose prevention education	18	23%
Wound care or other health services without sobriety requirements	13	16%
Peer support from people with lived experience of substance use	44	56%
We do not currently offer or connect clients to harm reduction services	8	10%
Other (please describe)	7	9%

Select all that apply. The base is respondents who selected at least one option (n = 79). Counts are people, not selections, so percentages sum to more than 100.

31. What barriers prevent your organization from implementing or expanding harm reduction practices? (Select all that apply)

Response category	Count	Percent (n = 90)
Funder restrictions or grant conditions that prohibit harm reduction	18	20%
Organizational or board-level opposition	9	10%
Community or neighborhood opposition	9	10%
Lack of staff training on harm reduction approaches	18	20%
Concerns about liability	17	19%
Lack of community partners or referral resources	12	13%
Uncertainty about legal status of some harm reduction tools in Oregon	9	10%
Harm reduction is not a barrier for us, we are where we need to be	22	24%
I don't know	40	44%
Other (please describe)	3	3%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

COORDINATED ENTRY AND REGIONAL COORDINATION

32. Does your organization participate in the local Coordinated Entry system?

Response category	Count	Percent (n = 90)
Yes, we are an access point/ we conduct assessments	45	50%
Yes, we receive referrals through Coordinated Entry	9	10%
Both, we conduct assessments and receive referrals	17	19%
We are in the process of connecting to the Coordinated Entry system	6	7%
No, we do not currently participate in Coordinated Entry	13	14%

The base is respondents who answered (n = 90).

33. Which vulnerability assessment tool(s) does your organization currently use? (Select all that apply)

Response category	Count	Percent (n = 73)
VI-SPDAT (Vulnerability Index, Service Prioritization Decision Assistance Tool)	33	45%
TAY-VI-SPDAT (youth version)	14	19%
Family VI-SPDAT	21	29%
We use an assessment tool but I am not sure which one	21	29%
We do not use a standardized vulnerability assessment tool	12	16%
Other (please specify)	2	3%

Select all that apply. The base is respondents who selected at least one option (n = 73). Counts are people, not selections, so percentages sum to more than 100.

34. How effectively does the Coordinated Entry system match people to appropriate housing and services in this region?

Response category	Count	Percent (n = 90)
Very effectively, people are matched to appropriate resources quickly	4	4%
Somewhat effectively, the system works but has significant gaps	29	32%
Not very effectively, matching is slow or often inappropriate	10	11%
Very poorly, the Coordinated Entry system is not functioning well	13	14%
I do not have enough visibility into the system to assess this	34	38%

The base is respondents who answered (n = 90).

35. What are the biggest gaps or problems with the current Coordinated Entry system in this region? (Select all that apply)

Response category	Count	Percent (n = 90)
Not enough housing or programs to refer people to, the list is long but resources are short	54	60%
Prioritization criteria exclude some high-need individuals	24	27%
The assessment tool may produce biased results for some populations	16	18%
Access points are not accessible to people in rural areas	13	14%
The system is not well understood by providers or clients	24	27%
Inconsistent assessment practices across organizations	18	20%
Poor communication about referral status and outcomes	30	33%
Limited capacity for re-assessment when circumstances change	14	16%
Coordinated Entry is working well, I do not see major problems	0	0%
I do not know.	27	30%
Other (please specify)	8	9%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%.

36. When clients need services your organization doesn't provide, how do you typically connect them to support?

Response category	Count	Percent (n = 90)
We maintain an active referral network and regularly connect clients to other organizations	58	64%
We make referrals occasionally but do not have a formal process or established relationships	14	16%
We provide information about other services but do not make direct referrals	16	18%
We do not typically refer clients to other organizations	2	2%

The base is respondents who answered (n = 90).

37. How well do organizations in this region coordinate on homelessness response?

Response category	Count	Percent (n = 90)
Very well, coordination is strong and consistent	11	12%
Fairly well, some coordination, but gaps remain	41	46%
Somewhat, coordination is inconsistent	29	32%
Poorly, organizations largely operate in silos	3	3%
Very poorly, lack of coordination creates serious problems	6	7%

The base is respondents who answered (n = 90).

38. What are the biggest barriers to effective coordination among providers? (Select all that apply)

Response category	Count	Percent (n = 89)
Lack of shared data systems or formal data sharing agreements	41	46%
Competing funding requirements that limit collaboration	31	35%
Organizational or turf conflicts	19	21%
Inadequate communication structures between agencies	46	52%
Insufficient staffing or capacity to coordinate	42	47%
Unclear roles and responsibilities across agencies	36	40%
Geographic barriers, urban vs. rural	17	19%
Lack of trust between organizations	11	12%
Privacy or HIPAA concerns that limit information sharing	30	34%
Other (please describe)	10	11%

Select all that apply. The base is respondents who selected at least one option (n = 89). Counts are people, not selections, so percentages sum to more than 100.

39. Does your organization have formal data sharing agreements with other agencies? (Select all that apply)

Response category	Count	Percent (n = 90)
Yes, with MWVCAA / ARCHES	28	31%
Yes, with the local Continuum of Care (CoC)	25	28%
Yes, with behavioral health or substance use providers	9	10%
Yes, with Marion or Polk County government	7	8%
Yes, with hospitals or health systems	8	9%
Yes, with criminal legal system partners (jails, probation, etc.)	4	4%
Yes, with other housing or shelter providers	11	12%
No, we do not have formal data sharing agreements	13	14%
We are working on establishing data sharing agreements	2	2%
I do not know.	42	47%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

40. Does your organization have a formal discharge planning process ensuring clients have stable housing or a warm handoff when leaving your program?

Response category	Count	Percent (n = 90)
Yes, we have a formal discharge planning protocol	30	33%
Yes, but it is inconsistently followed	7	8%
Informally, we try to connect clients to next steps but have no formal process	23	26%
No, we do not have a discharge planning process	9	10%
Not applicable to our program type	21	23%

The base is respondents who answered (n = 90).

41. Which populations do you believe are falling through the cracks in the current system? (Select all that apply)

Response category	Count	Percent (n = 89)
Families with children	29	33%
Single men	37	42%
Single women	32	36%
Single men with children	22	25%
Single women with children	20	22%
Youth and young adults (under 25)	31	35%
Older adults (55+)	53	60%
People with serious mental illness	64	72%
People with substance use disorders	50	56%
People with dual diagnoses	44	49%
Latinx / Hispanic individuals	25	28%
Indigenous / Native American individuals	24	27%
LGBTQ+ individuals	29	33%
People with disabilities	50	56%
Veterans	29	33%
Justice-involved / reentry population	31	35%
People in rural or outlying areas	31	35%
Farmworkers or agricultural workers	20	22%
People without ID or documentation	43	48%
People with pets	38	43%
People who do not meet sobriety requirements	34	38%
Other (please describe)	9	10%

Select all that apply. The base is respondents who selected at least one option (n = 89). Counts are people, not selections, so percentages sum to more than 100.

42. What are the biggest barriers your clients face when trying to access services in general? (Select all that apply)

Response category	Count	Percent (n = 90)
Lack of awareness about available services	70	78%
Transportation	72	80%
Long waitlists	72	80%
Eligibility requirements that exclude people	49	54%
Lack of services in their language	27	30%
Safety concerns about shelter environments	41	46%
Services not welcoming for their identity or culture	24	27%
Inability to bring pets or partners	53	59%
Criminal history or outstanding warrants	42	47%
Lack of ID or documentation	38	42%
Geographic distance, especially in rural areas	34	38%
Sobriety requirements	26	29%
No phone or internet access to find or contact services	58	64%
Other (please describe)	4	4%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

43. Does your organization employ peer support specialists, staff with their own lived experience of homelessness who work directly with clients? (Select one answer)

Response category	Count	Percent (n = 90)
Yes, peer support is a formal part of our workforce	43	48%
Yes, we have some peer staff but it is not formalized	23	26%
No, but we are interested in adding peer support capacity	2	2%
No, peer support is not part of our program model	7	8%
I don't know.	15	17%

The base is respondents who answered (n = 90).

44. Which data systems does your organization currently use to manage client and program data? (Select all that apply)

Response category	Count	Percent (n = 90)
HMIS (Homeless Management Information System)	66	73%
Electronic Health Record (EHR) system	15	17%
Salesforce or other CRM	4	4%
Custom internal database	19	21%
Spreadsheets (Excel, Google Sheets)	38	42%
Paper records only	3	3%
We do not systematically track client data	1	1%
I do not know.	12	13%
Other (please specify)	13	14%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

45. How complete and reliable is your organization's client data?

Response category	Count	Percent (n = 90)
We consistently collect complete, reliable client data across all key fields	38	42%
We collect client data but have gaps in some key fields or consistency issues	30	33%
We collect some client data but significant gaps limit its usefulness for reporting	3	3%
We collect client data but it is not reliable enough for reporting or analysis	2	2%
We do not collect client data in a systematic way	1	1%
I do not know.	16	18%

The base is respondents who answered (n = 90).

46. What client level data does your organization collect? (Select all that apply)

Response category	Count	Percent (n = 90)
Basic demographics (age, gender, race/ethnicity)	75	83%
Household composition and family status	67	74%
Geographic origin/ prior residence	54	60%
Housing status at intake and exit	65	72%
Length of time homeless at intake	59	66%
Income and employment status	63	70%
Disability status	66	73%
Veteran status (including discharge status)	65	72%
Criminal justice involvement	36	40%
Service utilization history	35	39%
Housing outcomes (placed, returned to homelessness, etc.)	47	52%
Client satisfaction or feedback	21	23%
Racial equity in outcomes (disaggregated outcome data by race)	12	13%
We do not collect any client data	0	0%
I don't know	14	16%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100. Options no one selected are shown as 0%.

47. Does your organization have staff capacity to analyze your own program data for decision-making?

Response category	Count	Percent (n = 90)
Yes, we have dedicated data or evaluation staff	29	32%
Somewhat, program or leadership staff do basic analysis	30	33%
Limited, we have data but lack capacity to analyze it meaningfully	4	4%
No, we do not have data analysis capacity	3	3%
I do not know	24	27%

The base is respondents who answered (n = 90).

48. How frequently does your organization use data to inform program decisions or report to funders?

Response category	Count	Percent (n = 90)
Regularly, data use is embedded in our decision-making	48	53%
Sometimes, we use data for reporting but not consistently for decisions	7	8%
Rarely, data is collected but infrequently used	2	2%
Not currently, we do not have a data-driven practice	1	1%
I do not know.	32	36%

The base is respondents who answered (n = 90).

49. What are the biggest barriers to better data collection and use at your organization? (Select all that apply)

Response category	Count	Percent (n = 90)
Staff capacity, not enough time or expertise	36	40%
Technology, systems are inadequate or difficult to use	12	13%
HMIS training and support gaps	20	22%
Funding, no dedicated resources for data or evaluation	16	18%
Competing priorities, data is deprioritized under operational demands	19	21%
Data sharing restriction, privacy or legal barriers	9	10%
Lack of leadership prioritization of data	10	11%
We need help knowing what data to collect and why	9	10%
Data quality, we collect it but can not trust the accuracy	6	7%
Data is not a significant barrier for us	10	11%
I do not know.	31	34%
Other (please specify)	2	2%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100.

50. What would most help improve data infrastructure and use across the regional homelessness response system?

Response category	Count	Percent (n = 90)
More HMIS training and technical assistance	26	29%
Clearer data sharing agreements across agencies	31	34%
A shared regional data dashboard showing real-time system capacity	34	38%
Standardized data collection tools and definitions across organizations	34	38%
A dedicated regional data coordinator or backbone organization	19	21%
Funding for data and evaluation capacity within organizations	21	23%
Regular learning convenings where providers review data together	13	14%
Better connection between CoC data and broader community planning	32	36%
Training on racial equity analysis of program outcomes	13	14%
I do not know.	35	39%
Other (please describe)	1	1%

Select all that apply. The base is respondents who selected at least one option (n = 90). Counts are people, not selections, so percentages sum to more than 100. The question did not state "select all," but the export records multiple selections per respondent.

SYSTEM STRENGTHS AND PRIORITIES

51. What is working well in the current homelessness response system that should be protected and expanded? [Open-ended, coded]

Response category	Count	Percent (n = 87)
Coordination, referrals, and partnerships	11	13%
Shelter capacity and shelter models (cabins, pods, safe parking)	10	11%
Outreach and community health workers	8	9%
Low-barrier and trauma-informed practice	8	9%
Rapid rehousing, rental assistance, and eviction prevention	7	8%
Case management, wraparound, and peer or lived-experience support	7	8%
Data collection and tracking	7	8%
Food, health care, and basic needs	5	6%
Transitional housing and the youth and family continuum	3	3%
Housing First and permanent housing	2	2%
Staff commitment	2	2%
Funding	1	1%
Culturally specific and multilingual services	1	1%
Other	8	9%
Don't know, or no answer	18	21%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 87), including responses coded as no answer.

52. What is the single most important change that would improve outcomes for people experiencing homelessness in this region? [Open-ended, coded]

Response category	Count	Percent (n = 90)
More affordable, permanent, or supportive housing	36	40%
More funding	13	14%
Coordination, communication, and referral systems	13	14%
Behavioral health and substance use treatment	8	9%
Staffing, training, and staff accountability	8	9%
More shelter capacity	7	8%
Low-barrier, harm reduction, and Housing First approaches	7	8%
Community awareness, education, and support	6	7%
Rental assistance, deposits, and eviction prevention	5	6%
Support after housing placement	5	6%
Outreach	3	3%
Sobriety expectations or higher-barrier programs	2	2%
Employment and job training	2	2%
Transportation	2	2%
Other	2	2%
Don't know, or no answer	3	3%

Open-ended, coded by theme. A response could receive more than one code, so percentages sum to more than 100. The base is respondents who answered (n = 90), including responses coded as no answer.

PARTICIPATION

53. Would you be willing to participate in a future small group discussion as part of the larger community needs assessment?

Response category	Count	Percent (n = 90)
Yes	62	69%
No	28	31%

The base is respondents who answered (n = 90).