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COMPLETE

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PAGE 2: Part 1: Demographics

Q1: **Choose your Continuum of Care Code:**	(MT-500) Montana Statewide CoC
Q2: **If you serve a Balance of State CoC, which counties is this update for?**	All Counties
Q3: **If you are submitting a plan for CA-600, what is the SPA number associated with your update?**	*Respondent skipped this question*

Q4: **Contact Information**

Name	Devin Kelley
Organization	Volunteers of America
Email Address	dkelley@voanr.org

PAGE 3: Part 2: Coordination

Q5: **Does your community have a written plan to end Veteran homelessness?**	No
Q6: **If you answered "Yes" to the previous question, have community stakeholders (e.g. local VA Medical Center, VA, SSVF grantees, etc.) provided input into the plan development and implementation?**	*Respondent skipped this question*

Q7: **Who is the CoC point of contact?**

Name:	Robert Buzzas
Email:	bobbuzzas@gmail.com
Organization:	Montana CoC Coalition
Phone #:	406-586-1572

Q8: Are representatives from the following VA funded programs present at community planning meetings/events?

	Strategic Meetings	Case Conferencing/Master List
HUD and Veterans Affairs Supportive Housing (HUD-VASH)	Not Applicable	Not Applicable
Healthcare for Homeless Veterans (HCHV)	Not Applicable	Not Applicable
Grant and Per Diem (GPD) VAMC Liaison	Not Applicable	Not Applicable
Grant and Per Diem (GPD) Providers	Not Applicable	Not Applicable
Community Resource and Referral Center (CRRC)	Not Applicable	Not Applicable
Domiciliary Care for Veterans (VA-Dom)	Not Applicable	Not Applicable
Veterans Justice Outreach (VJO)	Not Applicable	Not Applicable
Safe Haven	Not Applicable	Not Applicable

Q9: What types of data are community providers able to share with their local VA Medical Center(s)? (Select all that apply)	Client-level information (e.g. data from the HMIS system; includes identifying information such as the key elements for the by name/master list) , Aggregate performance information (e.g. housing placement numbers; length of time homeless, does not include identifying information)
Q10: What types of data can local VA Medical Center staff share with community providers? (Select all that apply)	Client-level information (e.g. data from the HOMES system such as key elements for the by name/master list) , Aggregate performance information (e.g. HUD-VASH placement numbers; length of time homeless, GPD information, does not include identifying information
Q11: Does your community have a standardized Release of Information (ROI) form for data sharing between the local VA Medical Center(s) and other relevant stakeholders?	No
Q12: If VA and non-VA homeless assistance providers are not able to share/receive data, which of the following would be helpful? (Select all that apply)	Sample ROIs and MOUs that other communities have used. , Assistance getting buy-in from the local VA Medical Center(s) to share data.
Q13: Is there a community-wide coordinated entry/assessment process for Veterans? Note: Participation in coordinated entry is a requirement of the SSVF program.	No

Q14: Who is lead point of contact for coordinated entry?

Name:	Robert Buzzas
Organization:	Montana CoC Coalition
Organization Type (VAMC, CoC, SSVF Grantee, etc.)	CoC
Phone #:	406-586-1572
Email:	bobbuzzas@gmail.com

Q15: Is the HUD-VASH program integrated into coordinated entry?	No
Q16: If the answer was "Yes" to the previous question, please select the response that best describes this integration:	*Respondent skipped this question*
Q17: Is the GPD program integrated into coordinated entry?	N/A
Q18: If the answer to the previous question was "Yes", please select the response that best describes this integration:	*Respondent skipped this question*
Q19: Is GPD providing bridge housing in the community? (Please note that they must have submitted a change of scope to the GPD Program Office or are currently in the process to select "Yes".)	No

Q20: Please list the GPD providers currently serving your community.

List of Agency Names	Independence Hall-Billings, MT; Willis Cruse-Helena, MT; Valor House-Missoula, MT
Total Number of Beds	20,12,17

Q21: Have any GPD providers in your community submitted a change of scope to the GPD Program Office?	No
Q22: If "No" to question 21, are any GPD providers planning to submit a change of scope?	No

PAGE 4: Part 3: Master List

Q23: Does the community have a master list?	Yes
Q24: If "Yes" to the previous question, is the list one complete document (not multiple parts)?	*Respondent skipped this question*

Q25: Who manages the master list?

Name:	Veterans Administration
Organization Type (VAMC, CoC, SSVF Grantee, etc.):	VA

Q26: Does your list have the following elements? (Select all that apply.)	Includes all unsheltered Veterans, Includes all Veterans in emergency shelter (regardless of shelter funding source) , Includes all Veterans in transitional housing (GPD, community TH, regardless of funding source)
Q27: How often do you meet to review and update the master list?	*Respondent skipped this question*
Q28: Currently what are your community's top 3 priorities for ending Veteran homelessness?	Data sharing, CoC engagement in planning efforts, Establishing a coordinated intake/entry system.

PAGE 5: Part 4: Meetings and Strategy

Q29: What types of meetings does your community have?

	(no label)
Case Conferences	No meetings occur.
Strategic Planning/CoordinationMeetings (Bigger Picture)	No meetings occur.

Q30: When are your next three strategic planning/coordination meetings? (Include date, time)	*Respondent skipped this question*
Q31: Would you like your Regional Coordinator and/or TA representative to participate in one of these meetings?	*Respondent skipped this question*

PAGE 6: Part 5: Federal Criteria/Benchmarks and Support

Q32: Has your community decided to pursue the federal partners' process?	No
Q33: If the answer to the previous question was "No", why have you decided not to pursue the process?	We are interested in pursuing the federal process but are unsure of the requirements, and training/TA needed.
Q34: Has your community submitted a claim to the federal partners (USICH, VA, HUD)?	No
Q35: If the answer to Question 34 was "Yes", please provide the date the claim was submitted and its current status (pending, approved, denied).	*Respondent skipped this question*

Q36: List any technical assistance needs. (Select all that apply.)	Assistance with by name list, Assistance with data sharing between VA and community and/or data tracking. , Assistance with CoC/stakeholder engagement

PAGE 7: Part 6: Sustainability

Q37: Has your community begun sustainability planning efforts?	No
Q38: What resource gaps (if any) have you identified that may hinder sustainability? Select all that apply	Need for additional prevention/rapid re-housing funds (non-SSVF) , Need for RRH Waiver to serve higher proportion of prevention clients in SSVF , Need for additional permanent supportive housing resources (VA and/or non-VA) , Need for affordable, permanent housing options, Funding for other intensive case management services for RRH Veterans currently housed but at-risk of returning to homelessness. , Other (please specify) Everything selected above has been identified as an organization not as a community or part of a community plan.
Q39: Does your community currently have Priority 1 (aka "Surge") SSVF funding?	Yes
Q40: If the answer to the previous question is "yes", does your community have adequate funding resources in place to sustain your system when "surge" funding ends?	No, If the answer is "no", please explain. Presently, the CoC in MT has been fragmented. Without consistent statewide CoCo engagement, a cohesive state plan, additional availability of affordable housing and additional funding for intensive case management, maintenance of current success will be at risk.
Q41: Does your community regularly follow-up with rapid re-housing clients to ensure housing stabilization?	Yes

Q42: Do you have a system in place to ensure rapid re-housing clients experiencing new housing crises are routed to prevention/other stabilization services?	Yes, If yes, please describe this process. Although the CoC is fragmented throughout the state, VOANR has established strong relationships with community resources to ensure that any veteran that is experiencing a new housing crisis is referred to the resource necessary to help the respective veteran receive the appropriate prevention/other stabilization service he/she needs.