A Framework to End Homelessness Among Veterans in the United States of America

John Kuhn

Department of Veterans Affairs, 1990 – 2025, USA[1]

Abstract_ *This article proposes building on a model known as One Team to rebalance resource allocation to address the root cause of homelessness: affordability. One Team is a person-centered, data-driven system of care that integrates housing, health, and social services across agencies. By creating intentional plans that also focus on those with less intensive service needs, policymakers can lower costs and free up new resources for development, while creating more sustainable communities. Pursuing these changes will create a system of care more responsive to the existing Veteran population seeking assistance and ultimately lead to reductions in both homelessness and future inflows into homelessness.*

Keywords_ *Veteran homelessness, integrated services, affordable housing, One Team*

Introduction

There has long been a two-tiered system of care for the homeless in the United States, with Veterans benefiting from enhanced services and greater access to affordable housing. Despite these advantages, homeless Veterans served in Los Angeles County face daunting challenges in the current socio-economic environment. Interventions will need to evolve to remain responsive to these changing conditions. Progress will be facilitated as LA County supports the move towards a person-centered system of care, one that integrates services across providers to

[1] Currently a consultant working for Los Angeles County developing a plan to end Veterans homelessness.

ISSN 2030-2762 / ISSN 2030-3106 online

meet the unique needs of each individual, as the best opportunity to successfully adapt to the current climate. It is an approach that represents a shift away from the traditional program-centered model, where individual agencies may compete to deliver care. Organizing services in this fashion often limits what is offered to an individual agency's capacity and its informal network. Instead, LA County has been moving forward with a cooperative system of care that is both more responsive and flexible, designed to address the needs of the individual seeking assistance.

This approach, known as One Team, prioritizes the shared mission of ending homelessness for every person encountered, regardless of their point of entry into the system. Rather than emphasizing the delivery of agency-specific services to as many individuals as possible, One Team partners focus on ensuring services are appropriately matched to individual needs. As a result, services provided through the One Team initiative are designed to respond to those served, rather than requiring individuals to conform to the model of care available through an individual agency.

To be effective, One Team must be supported by cohesive and empowered leadership that continuously adapts and improves services based on reliable data. While Housing First, an evidence-based practice widely recognized as a critical component of this homelessness response, remains an important element of any comprehensive system, it is not sufficient on its own. Two-thirds of individuals experiencing homelessness do not meet the federal definition of chronically homeless (HUD, 2026), the primary population intended to be served through Housing First interventions (Remaeus, 2011).

Given the disproportionate allocation of funding to meet the needs of the chronically homeless, (relative to the size of the overall homeless population), through the creation and ongoing operations of permanent supportive housing, it may be appropriate to reevaluate current funding commitments. If resources are aligned with need, this analysis suggests that additional investment should be directed toward more inclusive affordable housing strategies that more economically address the needs of the broader homeless Veteran population. Finally, a successful system of care must address the growing number of households at imminent risk of homelessness. Meeting the needs of this population is essential if efforts are to move beyond symptom management and toward a systemic response that addresses the root causes of homelessness.

Present Conditions

On any given night, more than 745 000 Americans experience homelessness (HUD, 2026), with millions more at risk of losing their housing. According to the most recently available Point-In-Time count (PIT) data, just over 10% of the Nation's approximately 32 500 homeless Veterans were located in LA County. Important policy and practice lessons can be drawn from this sub-population, as it has been the subject of significant national attention in the United States. Although homelessness is often attributed to mental health and substance use disorders, its primary driver is one that most Americans who pay rent or a mortgage readily understand: the high cost of housing. Prior to 1980, disabilities, mental health conditions, substance use disorders, and structural racism were present, yet homelessness at today's scale did not exist. What has changed is the well-documented decline in the availability of affordable housing.

Over the past 50 years, reductions in federal investment in affordable housing construction, combined with market forces, have driven rental and homeownership costs upward at a pace that has consistently exceeded income growth, particularly for lower-income households. As increasing numbers of households have been unable to afford housing, rates of homelessness have risen accordingly (Harati et al., 2025).

Since 1980, the affordability crisis has been further exacerbated by median rental costs far outpacing inflation, alongside a sharp decline in the supply of low-cost rental housing (Keys and Reina, 2025). The impact of these changes is reflected in the following two graphs, with the first graph showing the increases in median rents and the second graph showing the available supply of affordable housing, defined by constant 2023 dollars.

Figure 1. Median rent, 1980-2023 (2023 dollars)

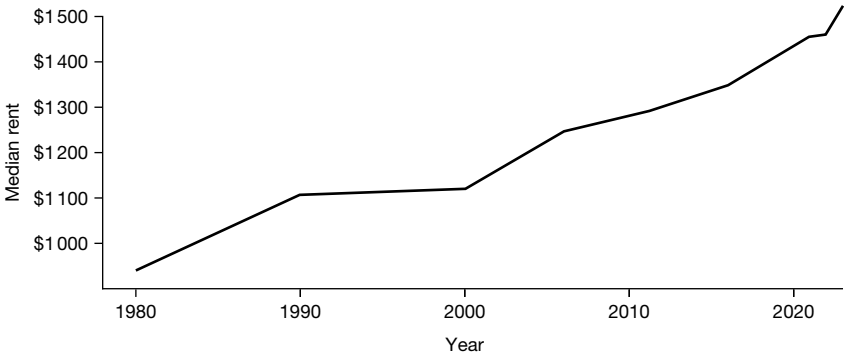
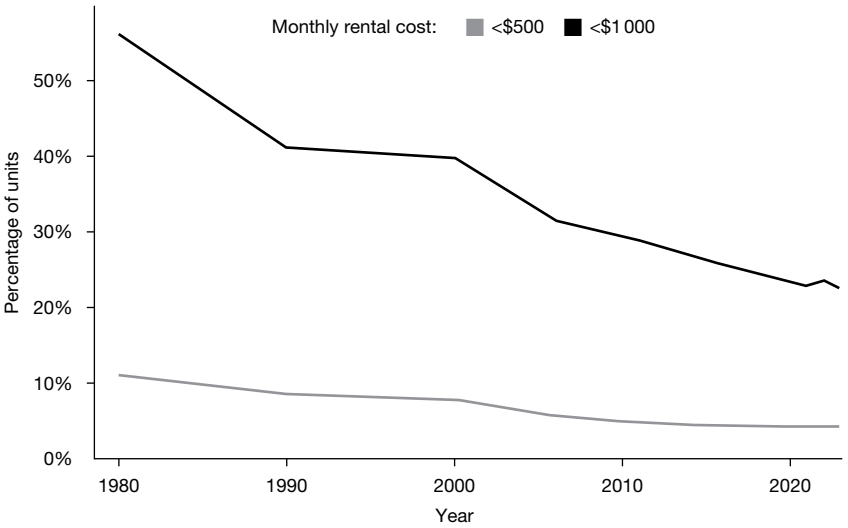


Figure 2. Percentage of monthly rental costs under $500 or under $1,000, 1980-2023 (2023 dollars)



Source: US Census Bureau, American Community Survey, 1980-2023

While the rise in homelessness has not been driven primarily by mental health or substance use disorders, homelessness itself carries profound health and mental health consequences that, when left unaddressed, can become significant barriers to regaining housing. Individuals experiencing homelessness face disproportionately high rates of HIV infection, substance use disorders, serious mental illness, tuberculosis, and other chronic and acute health conditions (CDC, 2024). Tens of thousands of Americans die while experiencing homelessness, with mortality rates approximately 3.5 times higher than those of housed populations (Meyer et al., 2023).

However, policymakers often mistake the consequences of homelessness for its causes, when in reality the relationship is bi-directional. Homelessness can precipitate or exacerbate disability, mental illness, and substance use disorders. This misattribution of causality fuels stigma and results in a misalignment of resources with actual need.

Although the lack of affordable housing remains the primary driver of homelessness, the traumatic health and mental health consequences of homelessness cannot be ignored. Once individuals become unhoused, untreated mental health and substance use disorders can rapidly worsen, making rehousing increasingly difficult and contributing to chronic homelessness. Veterans experiencing homelessness have significantly increased risk of substance use disorders, problematic gambling behaviors and suicidal ideation (Stefanovics et al., 2026). These higher

acuity populations, navigating multiple co-morbidities and past traumatic encounters with the homelessness response system, typically require intensive, ongoing supports to achieve and maintain housing stability.

As a result, homelessness has evolved into a public health emergency (Nelson et al., 2007), exposing large numbers of individuals to serious and immediate health risks that strain community systems. As demonstrated during the COVID-19 pandemic, these risks are magnified by limited access to care and by significant barriers to treatment adherence. These barriers include lack of transportation, absence of secure storage and refrigeration for medications and medical equipment, limited understanding of treatment plans, inadequate sanitation, and pervasive poverty. Compounding these challenges are the dismissive or indifferent attitudes many individuals experiencing homelessness encounter when seeking care.

Together, these factors complicate service delivery and contribute to learned helplessness, a psychological state in which individuals disengage from efforts to change their circumstances due to a perceived lack of control, making subsequent engagement more difficult. Faced with such challenges to engagement, staff must be prepared to consistently deliver on meaningful offers of assistance that are responsive to the Veteran's needs.

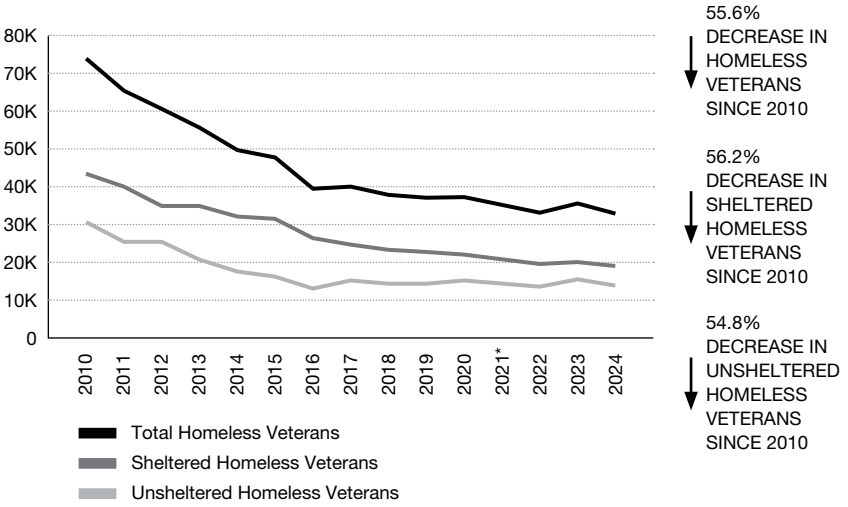
Addressing this public health emergency will require the mobilization of a broad array of institutions and resources capable of identifying, engaging, and supporting individuals and families whose needs extend well beyond housing alone. While addressing barriers to housing placement and retention remains essential and aligns with the evidence-based Housing First model, these efforts must be embedded within a broader, integrated strategy that can reach more people more effectively. Fragmented and compartmentalized systems of care must be aligned and coordinated to allow services to be flexible, responsive, and tailored to individual needs, an approach that lies at the core of the One Team initiative.

What Has Worked

One notable exception to national increases in homelessness is the substantial reduction in homelessness among Veterans. Successive administrations and Congress have prioritized ending Veteran homelessness, committing significant federal resources to this effort. Major investments in housing affordability and supportive services through the two significant housing programs funded by the federal government are central to that effort. One is a collaboration between the Department of Housing and Urban Development and the Department of Veterans Affairs, establishing and expanding a permanent supported housing program known as HUD-VASH. A second program, Supportive Services for Veteran Families

(SSVF), focuses on assisting those facing a short-term housing crisis, offering temporary services and financial assistance. These programs have helped hundreds of thousands of Veteran households obtain and maintain stable housing. Together, HUD-VASH and SSVF offer care that can be titrated to the needs of an individual or family, offering varying types of assistance at different levels of intensity based on need. Since 2010, Veteran homelessness has declined nationally by 55.6 percent, from 74 087 individuals to 32 882 in 2024 (HUD, 2024). In Los Angeles County, Veteran homelessness declined 58.1 percent, from 8 130 in 2011 (2010 figures are not available) to 3 408 in 2024.

Figure 3. The decline of veteran homelessness (2010-2024)



* Incomplete census due to Covid

A central feature of the VA's approach is ensuring that Veterans and their families can access and sustain permanent rental housing as quickly as possible, without preconditions, while simultaneously facilitating connections to health care, employment, childcare, and other supports that promote long-term housing stability and improved quality of life. These services are designed both to address immediate barriers to housing placement and to support households after the initial housing crisis has been resolved. An important flexibility of SSVF, and of the HUD-VASH voucher program, is that assistance can be extended to the Veteran's entire family. This feature is unlike most VA programs that serve only the Veteran. By helping families remain intact, these programs reduce the trauma and long-term adverse consequences associated with housing instability and family separation, particularly when some family members would otherwise remain unhoused.

The Los Angeles Housing Services Authority (LAHSA) reports that, according to point-in-time (PIT) data, Veteran homelessness in the Los Angeles CoC has declined by 21% between 2023 and 2025. These significant reductions, in contrast to national trends, are likely strongly correlated to improved system planning and coordination represented by One Team and suggest a potential model that can be employed in other communities.

Impact of Veteran Initiatives Has Declined

Although nationally, homelessness among Veterans has been reduced by more than half since 2010, the majority of this progress occurred by 2016, when the number declined by 47 percent from 74 087 to 39 471. As shown visibly on the previous graph, between 2016 and 2024, the further reduction to 32 882 represents a more modest 17 percent decline over a nine-year period (HUD, 2024). Strategies that proved effective during the early years of the initiative to end Veteran homelessness are now yielding diminishing returns. This slowdown, despite continued growth in VA investments, suggests the need for new and adaptive approaches.

The deceleration in progress reflects two primary factors. First, the persistent shortage of affordable housing remains a central driver of homelessness and has worsened substantially over the past decade, particularly as COVID-era housing inflation accelerated rent growth and further constrained already limited affordable housing supply. As shown in earlier figures, rising rents and declining affordability show little indication of reversing. Second, Veterans currently experiencing homelessness face more complex and intensive needs than those served when the initiative began. In 2015, 55 percent of SSVF participants had a disabling condition; by 2023, that share had increased to 70 percent (VA, 2024). This shift is closely tied to the aging of the homeless Veteran population, with approximately half of SSVF participants in 2024 aged 55 or older. These trends point to the growing need for housing models that incorporate assisted living options and access to homemaker or home health aide supports.

Thus, while early successes understandably encouraged continued reliance on previously effective strategies, changing conditions now require a recalibration of approach. Because the current challenges stem from both worsening housing affordability and the increasing acuity of need, particularly among unsheltered homeless Veterans, future progress will depend on a comprehensive strategy that simultaneously addresses the immediate service and housing needs of today's homeless Veterans. This immediate challenge must be faced while also confronting the structural affordability constraints that, if left unresolved, will continue to generate new inflows into homelessness.

LA County has begun this process of recalibration.

Revitalizing the Effort to End Homelessness

1. A Data System that Identifies and Tracks Veterans Experiencing Homelessness

Creating a by-name list (BNL) enables communities to identify individuals experiencing homelessness, assign care and service plans, and track progress toward permanent housing in real time. It also provides communities with visibility into system-level challenges, allowing them to identify operational, policy, and resource barriers that impede efforts to end homelessness. As such, the BNL can serve as the foundation of an effective, coordinated system response to homelessness when all stakeholders, such as the VA, Continuum of Care, and Housing Authorities, are committed to the coordination of care through this best practice.

Effective BNLs are most often developed using the locally administered, HUD-mandated Homeless Management Information System (HMIS), which providers are expected to access and use to document services. For HMIS to function as a reliable repository for a BNL, participating providers must update participant status at least monthly, and data entry must include standardized, agreed-upon fields that are sufficient to monitor client progress and support informed case conferencing. Furthermore, these updates should include data validity checks that review the accuracy of data and make corrections and changes to client-level data as it becomes known.

It will be incumbent on One Team partners, in collaboration with LAHSA, to run validity checks no less than monthly on HMIS data to ensure accuracy. The regular updating and review of data are vital to creating a BNL that can be reliably used for understanding current demand, informing planning for Veterans and their families, and allocating resources.

2. Making Emergency Housing Available On-Demand

Communities must do better at moving people off the streets, where they are exposed to repeated trauma, unsafe and unsanitary conditions, and circumstances that undermine both their well-being and the quality of life in surrounding neighborhoods, often reinforcing NIMBY opposition that complicates the development of new housing and services. Temporary shelter that is responsive to basic human needs and offers safe conditions with a degree of privacy is more likely to encourage unsheltered individuals to accept assistance. Even congregate settings can foster a sense of personal space through the use of semi-enclosed bays, partitions, and thoughtful design.

Emergency housing options are also more effective when they are not burdened by unnecessary restrictions and requirements that frequently deter unsheltered individuals from seeking shelter. In addition, shelters must include options that allow families to remain together. Appropriate temporary accommodations, including hotel and motel-based options, are essential to enable service providers to engage consistently with clients, complete permanent housing plans, and deliver other critical supports.

That said, as service providers routinely observe, even when safe and accessible shelter options are available, some individuals will choose to remain unsheltered. This choice places both the individual and the broader community at risk. In some cases, the decision to decline reasonable shelter may reflect impaired judgment associated with prolonged trauma, mental illness, or substance use disorders. Leaving individuals in unsheltered settings under these conditions exposes them to serious harm and creates public health risks. Accordingly, systems must retain carefully defined involuntary placement options for the unsheltered when appropriate temporary housing is routinely declined. Currently, VA maintains sufficient capacity to provide shelter to Veterans through its Grant and Per Diem (GPD) transitional housing and Health Care for Homeless Veterans (HCHV) contract residential services programs. While nightly occupancy varies, on any night, scores of available beds are available. As of April 8, 2026, VA had 182 open beds out of a total of 781 operational interim housing beds in the Los Angeles area. This total does not include temporary motel/hotel beds available through SSVF. Public leaders must be willing to acknowledge this reality and establish pathways that prioritize removing people from the streets, preventing further trauma, and mitigating the severe health consequences of continued unsheltered homelessness. The active involvement of LA County departments, particularly the Department of Mental Health (DMH), and access to health care through Medi-Cal and Covered California will be vital to ensure Veteran ineligible for or refuse VA care have access to needed treatment resources.

3. Increasing the supply of affordable housing

A. Housing First

It is important to begin with a discussion of the dominant model of homeless intervention, Housing First, to understand its role within the broader strategy to end homelessness. Following this overview, the report will address strategies to accelerate the development of affordable housing. Housing First is a proven, evidence-based approach designed to resolve homelessness for individuals with a serious mental illness. By providing intensive support to persons housed in apartments scattered throughout the community (Remaeus, 2011), Housing First has success-

fully engaged a population that is otherwise difficult to reach. As noted in the introduction, this service model remains critically important for serving homeless individuals with long-term, intensive service needs.

However, Housing First was primarily designed to serve the roughly one-third of the homeless population who are chronically homeless. Over time, the term has become a catch-all for strategies to end all homelessness, and its application to broader populations, without supporting evidence, can produce unintended consequences. For example, the focus on chronically homeless individuals has led to funding models that prioritize buildings exclusively for permanent supportive housing (PSH) rather than funding housing that is affordable but does not emphasize case management and other service supports. The principal alternative option available to Veterans is the time-limited subsidy (TLS) program, such as VA's SSVF program, which provides homeless and at-risk Veterans with a pathway into the commercial housing market. However, the subsidies offered are, by definition, time-limited. For those navigating a temporary housing crisis, such support is sufficient, but for those impoverished Veterans who will continue to be unable to afford market-rate rents, once TLS subsidies end, longer-term supports would be needed so they can remain housed. The many Veterans who only need affordable rentals to avoid homelessness would benefit from an intentional plan that offers sustainable affordable housing without the unneeded and unnecessary costs associated with PSH intensive services.

Moreover, concentrating the placement of individuals with serious mental health or substance use disorders into project-based buildings while labeling this "Housing First" misapplies the model, which was originally designed for scattered-site housing. Such concentration can destabilize residents and the surrounding community, creating environments resembling lightly supervised psychiatric wards, jeopardizing tenant safety, sobriety, and mental health, while reinforcing NIMBY opposition.

By contrast, strategies that emphasize affordable housing foster mixed communities more representative of the broader population and avoid concentrating high-need individuals in ways that can undermine outcomes. Mixed-population housing aligns more closely with the evidence-based scattered-site Housing First model, reduces per-unit operational costs, and helps mitigate local opposition, thereby supporting the broader development of affordable housing.

B. Creating Affordable Housing

The cost of developing PSH is high and unsustainable. For example, the average cost to develop a new unit of PSH on the VA's West LA Campus is $750 000, not including the value of the land, provided at no charge. Such costs are not unusual for affordable housing in Los Angeles (Rohrlich, 2023). Several factors contribute to these high costs, including environmental review requirements that add delays

and expenses, mandates to use unionized labor or equivalent wage standards, set-asides for service-disabled veteran-owned small businesses (SDVOSBs), the complexities of applying for low-income housing tax credits (LIHTC), and coordinating the need for and requirements of multiple funding streams. While each of these requirements may offer important benefits, collectively they reduce competition, increase costs, and slow the pace of housing production.

4. One-Team

Homeless programs are often designed to address specific areas of need, such as outreach, housing, mental health services, or employment, but people do not fit neatly into program categories. Program-centered designs are therefore inherently limited, often unresponsive, and inefficient. A person-centered approach, in contrast, asks, "What does this individual need?" rather than "What can our program offer?" In this approach, the program that serves as the entry point into the system draws on the resources of all available programs to develop a comprehensive plan. Staff focus shifts from the program to the person.

One Team seeks to deliver integrated, Veteran-centric care that moves beyond traditional, entry-point–based approaches, where referrals occur only after program options are exhausted. One Team presents Veterans with an integrated housing and service plan that leverages resources from multiple programs as needed to achieve the Veteran's goals and the community's objective of sustainable housing. Housing and services are coordinated from the outset, with staff from each program working collaboratively to ensure a single, dynamic, Veteran-centric plan that evolves as needs change.

One Team identifies all Veterans experiencing homelessness, rapidly triages them to safe, temporary housing, and uses case conferencing, housing navigation, and intentional service bridges to place Veterans into permanent housing with an aftercare plan. Regular case conferencing is the vehicle One Team has used to organize assignment of care and track progress. Changes in care and progress towards both emergency and permanent housing placement are tracked in the BNL

Central to this effort is One Team's creation of a leadership team, known as the Executive Committee, that is empowered to drive system design and continuous improvement. The Executive Steering Committee is comprised of system leaders who meet in person monthly and will drive decision-making in LA County. The Executive Committee can charge committees to focus on specific areas of local need, with some committees being permanent and others time-limited, depending on the priorities and challenges identified.

5. Prevention

Homelessness prevention is often mistaken for eviction prevention, yet research indicates it is difficult to predict if those who are at risk will become homeless. (Shinn et al., 2013). Because actual risk is difficult to measure, prevention must encompass a broad spectrum of individuals, ranging from those imminently at risk to those experiencing "upstream" risk in unstable housing environments.

Imminently at-risk individuals are defined by HUD and SSVF as those within 14 days of losing their primary residence, without a next residence identified, and lacking the financial or social resources to secure housing. Upstream at-risk individuals may not face immediate displacement but live in highly unstable or precarious environments that make future homelessness more likely.

At-risk populations also extend beyond those living in private residences, including individuals in institutions such as those found in the criminal justice system, residential treatment facilities, and other healthcare settings. According to the Prison Policy Initiative, "People who have been to prison just once experience homelessness at a rate nearly 7 times higher than the general public. But people who have been incarcerated more than once have rates 13 times higher than the general public (Couloute, 2018)." Involving representatives of the criminal justice system as well as others serving Veterans in other institutional settings will be critical to the planning needed to ensure Veterans discharged from these settings do not end up on the streets.

Upstream risks can be attenuated by ensuring that Veterans are aware of benefits and entitlements that they are eligible to receive. These income and income-related forms of assistance can be the difference in helping Veterans and their families sustain housing. Yet according to a 2011 RAND study, over 40 percent of Veterans claimed a lack of understanding of benefits available to them, and over 25 percent said they don't know how to get their questions about benefits answered. A November 2021 US Department of Health and Human Services brief, *Participation in the U.S. Social Safety Net: Coverage of Low-Income Families*, provided further evidence that many of those eligible for benefits failed to get these supports. Participation rates in the general population were well below what could be expected based on eligibility, with participation as low as 28% for Temporary Assistance to Needy Families (TANF) and as high as 75% for Medicaid. Low rates of participation may reflect challenges faced by potential applicants trying to navigate changing and confusing eligibility requirements, the shame experienced applying for assistance, and limited outreach informing potential recipients of their eligibility.

Because risk arises from multiple contexts and is difficult to quantify, prevention interventions must be layered, setting-specific, and scalable, escalating in intensity based on the individual's assessed risk. By deploying a layered, risk-informed approach, communities can prevent homelessness more efficiently, address diverse needs, and reduce inflows into emergency housing and shelter systems.

Final Thoughts

The current system of care and resource allocation has become imbalanced. Focusing too heavily on people with the highest-intensity needs leaves many others, those who are homeless or at imminent risk, without sufficient support. As a result, a large share of individuals who require assistance but do not qualify for PSH remain underserved, driving continued inflows into homelessness. While services for people with complex needs are essential, an overemphasis on the most visible forms of homelessness excludes too many who also need help.

If we accept that the primary driver of homelessness is a shortage of affordable housing, and that mental health challenges, while significant, are not the root cause, then resource allocation should reflect that understanding. A useful parallel can be found in healthcare systems that provide intensive, high-acuity services such as emergency and inpatient care, but most care should be delivered in community-based, outpatient settings. The homelessness response system should strive for a similar balance, ensuring that resources are distributed in a way that addresses both urgent needs and attends to the broader demands for housing assistance without the expectation of ongoing or intensive case management.

We live in a dynamic, ever-changing world, and so do the individuals who are homeless or at-risk of homelessness. Intervention models must evolve to remain relevant and effective in addressing these shifting needs. As strategies to end homelessness continue to develop, it is critical to establish a dynamic, adaptable system capable of responding to changing conditions.

Ultimately, the ability of the homeless system of care to adapt depends on strong leadership. Effective leadership ensures the integration of all system components, allocates resources efficiently, invests in staff training, supports robust data systems to maintain an accurate BNL, and prioritizes the time required for planning and case conferencing. Without this commitment, even the most well-designed models will struggle to achieve their intended outcomes.

References

Couloute, L. (2018). *Nowhere to go: Homelessness among formerly incarcerated people*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/housing.html

Harati, R., Emmanual, D., Renzr, K., & Aurand, A. (2025). *The gap: A shortage of affordable homes*. National Low-Income Housing Coalition. https://nlihc.org/sites/default/files/gap/2025/gap-report_2025_english.pdf

Keys, B., & Reina, V. (2025). Improving housing affordability. In M. S. Kearney & L. Pardue (Eds.), *Advancing America's prosperity*. Aspen Institute. https://doi.org/10.5281/zenodo.17429048

Macartney, S., & Ghertner, R. (2021). *Participation in the U.S. social safety net: Coverage of low-income families, 2018*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/9e9000cb7b1e4e30c2e616e547ed9bd9/program-eligibility-participation-brief-december-2021.pdf

Meyer, B., Wyse, A., & Logani, I. (2023). *Life and death at the margins of society: The mortality of the U.S. homeless population* (NBER Working Paper No. 31843). National Bureau of Economic Research.

Stefanovics, E.A., Tsai, J., Fischer, I. Na, P., Nichter, B., Potenza, M., & Pietrzak, R. (2026). Homelessness Among U.S. Veterans: National Trends, Correlates, and Mental Health Burden. *Journal of Community Health*. https://doi.org/10.1007/s10900-026-01588-5

Nelson, C., Lurie, N., Wasserman, J., & Zakowski, S. (2007). Conceptualizing and defining public health emergency preparedness. *American Journal of Public Health, 97*(Suppl. 1), S9–S11.

Remaeus, A., and Jönsson, A. (2011). A review of Sam Tsemberis's, Housing First: The pathways model to end homelessness for people with mental illness and addiction manual*. European Journal of Homelessness*, *5*(2) 235-240.

Rohrlich, T. (2023, March 21). *In LA, costs climb for building 'affordable housing.' $600K for a single unit is the median*. LAist. https://laist.com/news/housing-homelessness/affordable-housing-lihtc-la-rent-housing-developers-financing-boyle-heights-low-income

Shinn, M., Greer, A. L., Bainbridge, J., Kwon, J., & Zuiderveen, S. (2013). Efficient targeting of homelessness prevention services for families. *American Journal of Public Health, 103*(S2), S324–S330.

Steele, J., Salcedo, N., & Coley, J. (2011). *Military veterans' experiences using the Post-9/11 GI Bill and pursuing postsecondary education*. RAND Corporation. https://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG1083.pdf

U.S. Centers for Disease Control and Prevention. (2024). *About homelessness and health*. https://www.cdc.gov/homelessness-and-health/about/index.html

U.S. Department of Housing and Urban Development. (2024). *The 2024 Annual Homeless Assessment Report (AHAR) to Congress: Part 1: Point-in-time estimates of homelessness*. https://www.huduser.gov/portal/sites/default/files/pdf/2024-AHAR-Part-1.pdf

U.S. Department of Housing and Urban Development. (2026). *The 2025 Annual Homeless Assessment Report (AHAR) to Congress: Part 1: Point-in-time estimates of homelessness*. https://www.huduser.gov/portal/sites/default/files/pdf/2025-AHAR-Part-1.pdf

U.S. Department of Veterans Affairs. (2024). *FY 2024 annual report: Supportive Services for Veteran Families (SSVF)*. https://www.va.gov/HOMELESS/ssvf/docs/SSVF_Annual_Report_FY2024.pdf