Analysis of Veteran Homelessness in Lubbock, Texas: Targeted Count and System Evaluation Report

Prepared by ECHO West Texas

Executive Summary

Veterans experiencing housing instability represent a highly distinct subpopulation within our local homeless response system, offering a clear opportunity for targeted clinical, social, and housing interventions. To accurately capture this population and build upon routine Point-in-Time (PIT) activities, ECHO West Texas—acting as the lead agency for the Lubbock City & County Continuum of Care (CoC TX-625)—partnered with the City of Lubbock Veteran Advisory Committee (VAC), local Veteran Service Organizations (VSOs), and the U.S. Department of Veterans Affairs (VA) to execute a dedicated, county-wide Veteran Count on October 15 and 16, 2026.

This analysis evaluates a total dataset of 77 U.S. military veterans identified across system enrollment records and specialized street outreach surveys. The evaluation applies a dual lens, examining housing status alongside active system engagement statuses (active under 30 days, 30-day inactive, and 60+ day inactive) to assess population stability, outreach retention, and service utilization across the Continuum of Care.

The findings reveal a population with divided needs. Of the 77 veterans evaluated, 51 veterans (66.2%) are permanently housed through supportive housing, rapid rehousing, or homelessness prevention programs. Conversely, 26 veterans (33.8%) remain actively experiencing homelessness, comprising 6

sheltered veterans in emergency or transitional facilities and 20 unsheltered veterans living on the streets, in vehicles, or in makeshift encampments.

An important insight gained from this effort is the presence of chronic, repeated homelessness among unhoused veterans. Over 61% of veterans with recorded homelessness history (16 out of 26 valid responses) report multiple episodes of homelessness over the past three years rather than a first-time crisis. Furthermore, system engagement metrics indicate that 60% of the unsheltered veteran cohort (12 out of 20) are currently inactive in the Homeless Management Information System (HMIS) for 30 to 60+ days, presenting a vital opportunity to strengthen the bridge between street outreach operations and sustained case management.

Demographic and health evaluations demonstrate significant complex needs across the system. Female veterans constitute 20.8% of the population, 18.2% of veterans maintain immediate family dependents including spouses, and over 48% of veterans with known ages are 50 years of age or older. Health data underscores a heavy burden of substance use disorders, physical disabilities, and co-occurring health conditions among unhoused veterans. However, structural, and regulatory data collection gaps obscure the full health profile of housed veterans receiving assistance.

Supporting veteran housing stability in Lubbock is an achievable goal that will benefit from moving toward real-time, systematic coordination. Key recommendations focus on establishing an active, real-time Veteran By-Name List (BNL), harmonizing standardized disability data collection across all partner agencies, expanding low-barrier Permanent Supportive Housing (PSH) linked with VA clinical care, and developing specialized housing pathways for female veterans and veteran families.

Purpose and Background

The Lubbock City & County Continuum of Care (TX-625) oversees the regional homeless response infrastructure across Lubbock County, Texas. As the designated Collaborative Applicant and Coordinated Entry/HMIS Lead Agency, ECHO West Texas coordinates housing inventory planning, coordinated entry pathways, system performance measurements, and federal reporting to the U.S. Department of Housing and Urban Development (HUD).

Historically, community-wide PIT counts conducted during the last ten days of January have faced inherent methodological limits in fully reflecting the scope of veteran housing needs. Service members experiencing housing loss may navigate housing challenges in unique ways—residing in dispersed rural encampments, vehicles, temporary structures, or informal doubling-up arrangements. This specialized count offered a constructive way to bring enhanced visibility to these individuals.

Building on previous count benchmarks, community stakeholders proactively collaborated in August of 2026 to design a dedicated, veteran-specific count and vulnerability assessment. Led by ECHO West Texas in partnership with the City of Lubbock Veteran Advisory Committee, local VSOs, and local VA Medical Center personnel, this collaborative mission aimed to establish a robust baseline of veteran housing needs ahead of Veterans Day 2026.

The initiative was designed to achieve four primary objectives:

1. Identify causes for prior undercounting.
2. Quantify the scope of sheltered and unsheltered veteran homelessness across Lubbock County using specialized peer-led outreach strategies.
3. Identify demographic trends, health vulnerabilities, service gaps, and structural barriers that impede veterans from securing permanent housing.

4. Inform local resource allocation, refine Coordinated Entry prioritization, and support federal grant applications to bring targeted housing subsidies to the region.

To foster peer trust and facilitate authentic engagement, volunteer recruitment explicitly prioritized U.S. military veterans from all branches and discharge statuses, veterans with lived experience of housing instability, VSO representatives, and VA Housing First staff. Outreach operations combined targeted street sweeps of known hot spots, such as urban parks, transit hubs, vacant structures, and encampments.

Methodology and Limitations

While single-night Point-in-Time (PIT) counts provide critical snapshot data, they inherently undercount total homelessness across any population. Developing an accurate, actionable picture of housing instability requires sustained, ongoing street outreach paired with continuous system engagement to identify and connect with unhoused individuals.

The analysis evaluates client-level records derived from the Continuum of Care HMIS and field surveys administered during the October 15–16, 2026 count. The dataset contains 77 unique records, structured according to standardized HMIS data elements and custom community survey fields. These custom survey fields were added to the street outreach surveys; however, the limited number of street survey responses does not allow for an analysis of those responses.

Certain programs represented in the dataset (43 of 51 housed enrollment records in HMIS) do not collect specific disability sub-types for several reasons, including regulatory considerations. This creates a valuable opportunity for regional partners to collaborate on refining data collection frameworks, ensuring a more comprehensive understanding of health trends among permanently housed veterans as we work together toward functional zero.

Additionally, field survey records offer initial demographic insights, providing an excellent foundation for ongoing outreach teams to build rapport and gather deeper health, disability, and income information over time. All percentage calculations for specific conditions are grounded strictly in valid, complete responses.

The count strategy is in the Appendix of this report. Due to the compressed timeline of this count, the planning group was unable to conduct focus groups that may have helped target hot spots and early interventions, so the planning group functioned as an informal focus group in addition to its planning activities. Future counts are encouraged to conduct such focus groups to elicit more information prior to the count.

Quick Reference Snapshot

Housing Status

Housing Status Classification	Active (<30 Days)	Inactive (30–59 Days)	Inactive (60+ Days)	Total Veterans	Percentage of Total
Permanently Housed	51	0	0	51	66.2%
Sheltered (Emergency/Transitional)	6	0	0	6	7.8%
Literally Homeless (Unsheltered)	8	4	8	20	26.0%
Total Population	**65**	**4**	**8**	**77**	**100.0%**

Active = actively engaged in services and/or has been engaged by outreach in last 30 days

Inactive = not actively engaged in services and/or has not been engaged by street outreach in the specified time period

Demographic Breakdown of Identified Veterans

Demographic	Category / Range	Client Count	Percentage of Known Total
U.S. Military Veteran Status	Confirmed Veteran	77	100.0%
Sex	Male	61	79.2%
	Female	16	20.8%
Age Distribution *(74 responses)*	20–29 Years	10	13.5%
	30–39 Years	14	18.9%
	40–49 Years	14	18.9%
	50–59 Years	15	20.3%
	60–69 Years	17	23.0%
	70–79 Years	3	4.1%
	80+ Years	1	1.4%
	Missing / Unspecified Age	3	--
Race & Ethnicity	White (Non-Hispanic)	37	48.1%
	Hispanic / Latina / o (Any Race)	21	27.3%
	Black / African American	12	15.6%
	Multiracial (White & Hispanic)	4	5.2%
	American Indian / Alaska Native	1	1.3%
	Multiracial / Other	2	2.6%

Demographic	Category / Range	Client Count	Percentage of Known Total
Family Composition	Single Individual (No Dependents)	62	80.5%
	Veteran with Dependents (including spouses)	14	18.2%
	Unspecified / Missing	1	1.3%

Health Vulnerabilities and Disability Prevalence by Housing Status

Health / Disability Indicator	Housed Veterans (N=51 Active)	Sheltered Veterans (N=6 Active)	Unsheltered Homeless (N=20 Total)	Combined System Total
First-Time Homelessness *(Yes / No)*	Not applicable	4 Yes / 2 No	5 Yes / 13 No *(2 n/a)*	9 Yes / 15 No *(2 n/a)*
Overall Disabling Condition	13 Yes / 27 No *(11 n/a)*	4 Yes / 2 No	10 Yes / 10 No	27 Yes / 39 No *(11 n/a)*
Substance Use Disorder (SUD)	11 Yes / 36 No *(4 n/a)*	0 Yes / 6 No	6 Yes / 12 No *(2 n/a)*	17 Yes / 54 No *(6 n/a)*
Chronic Health Condition	5 Yes / 42 No *(4 n/a)*	0 Yes / 6 No	3 Yes / 15 No *(2 n/a)*	8 Yes / 63 No *(6 n/a)*
Mental Health Condition	2 Yes / 45 No *(4 n/a)*	2 Yes / 4 No	5 Yes / 13 No *(2 n/a)*	9 Yes / 62 No *(6 n/a)*
Physical Disability	6 Yes / 41 No *(4 n/a)*	2 Yes / 4 No	6 Yes / 12 No *(2 n/a)*	14 Yes / 57 No *(6 n/a)*

Population Analysis: Demographics, Health, and Vulnerabilities

Demographic Profile and Generational Cohorts

The total analyzed population of 77 U.S. military veterans exhibits demographic diversity alongside notable concentrations of vulnerability that require specialized intervention. Gender distribution reflects a significant female veteran presence, with 61 veterans identifying as male (79.2%) and 16 as female (20.8%). The 20.8% female veteran proportion is markedly higher than national veteran homeless averages, which historically hover between 9% and 11%, pointing to specific local drivers of female veteran distress. Female veterans in homeless

response systems frequently present with distinct trauma histories, including Military Sexual Trauma and intimate partner violence, necessitating gender-specific, trauma-informed housing environments.

Age analysis across the 74 veterans with recorded age data reveals a distinct distribution heavily weighted toward older adulthood. Young adult veterans aged 20 to 29 represent 10 individuals (13.5%), who often face intense reintegration shocks, early service disconnection, and acute mental health struggles. Veterans aged 30 to 49 represent 28 individuals (37.8%), comprising 14 veterans aged 30 to 39 and 14 veterans aged 40 to 49. This cohort represents a major functional group in the system, experiencing economic disruption, family strain, and escalating substance use.

Aging and senior veterans aged 50+ represent 36 individuals (48.6%), comprising 15 veterans aged 50 to 59, 17 veterans aged 60 to 69, 3 veterans aged 70 to 79, and 1 veteran aged 82. The concentration of veterans over age 50 represents a major structural challenge for Lubbock County. Aging veterans experiencing homelessness suffer from accelerated cognitive and physical decline, chronic comorbidities, and complex mobility limitations. The presence of senior veterans, including octogenarians, on the street or in emergency shelters indicates severe gaps in assisted living, permanent supportive housing, and medical respite facilities or gaps in meaningful outreach engagement to prepare these individuals for housing.

Racial and ethnic distribution illustrates that minority veterans are slightly overrepresented in housing distress relative to general county demographics. White veterans account for 37 records (48.1%), Hispanic veterans account for 21 records (27.3%), and Black/African American veterans account for 12 records (15.6%). Multiracial and Indigenous veterans account for the remaining 7 records (9.1%). System planning should integrate culturally competent outreach and case management to ensure equitable service delivery.

Furthermore, family composition metrics reveal that 14 veterans (18.2%) maintain immediate family dependents, including minor children and spouses. Housing a veteran with dependents requires multi-bedroom rental units, childcare support, and family-centered case management, resources that differ from single-adult emergency shelter configurations.

Active System Engagement and Housing Status Analysis

Cross-analyzing housing status against active system records provides insights into outreach effectiveness and client retention. The data demonstrates absolute operational stability among housed and sheltered cohorts. All 51 permanently housed veterans and all 6 sheltered veterans maintain fully active (<30 days) system records. This active engagement reflects continuous monthly contact between housed clients and housing stability caseworkers, ensuring that rental subsidies and supportive services remain intact.

Conversely, the 20 unsheltered homeless veterans exhibit critical system drop-off. Only 8 unsheltered veterans (40.0%) maintain active (<30 days) status. Meanwhile, 4 unsheltered veterans (20.0%) are inactive 30 to 59 days, and 8 unsheltered veterans (40.0%) are inactive 60+ days. In total, 12 out of 20 (60.0%) literally homeless unsheltered veterans in Lubbock are inactive in the system database.

This inactivity rate highlights a clear path forward for enhancing engagement: transitioning initial street outreach contacts into continuous housing navigation. By maintaining ongoing touchpoints, service providers can preserve spatial awareness, streamline housing documentation, and rapidly connect unsheltered veterans with eligible VA benefits.

Homelessness History, Chronicity, and System Recidivism

Evaluating homelessness history reveals that homelessness among Lubbock current homeless veterans is overwhelmingly chronic and recurrent rather than an acute, first-time occurrence. Of the 26 homeless veteran records, 10 are first-time homeless, and 16 are repeat or chronically homelessness. Among the 18 unsheltered veterans with valid homelessness history responses, 13 individuals (72.2%) report that this is not their first time experiencing homelessness, confirming two or more separate episodes of homelessness within the last three years. Only 5 unsheltered veterans (27.8%) represent a first-time homeless crisis. Similarly, among the 6 sheltered veterans, 2 individuals (33.3%) have recurrent homeless histories and 4 (66.7%) represent first-time episodes.

Understanding these recurring patterns helps highlight where system design can evolve. Chronically unhoused veterans often develop self-reliant survival strategies, illustrating the importance of continuous, trust-based peer engagement to reconnect them with comprehensive support networks. This high chronicity rate indicates that mainstream emergency interventions have been unable to break the cycle of instability for these individuals. Veterans experiencing chronic homelessness build entrenched survival mechanisms on the street, leading to deep institutional distrust and disengagement from traditional care networks.

In contrast, among permanently housed veterans, supportive housing programs in Lubbock are successfully stabilizing long-term, chronically homeless veterans when enrollment is achieved and the veteran is successfully integrated into a housed lifestyle.

Health Profile and Disability Sub-Type Analysis

The intersection of physical disability, mental health disorders, and substance use disorders creates extreme vulnerability among unhoused veterans.

Substance Use Disorder (SUD) represents the single most prevalent reported health condition across the entire veteran system, impacting 17 total veterans. Among unsheltered veterans with valid data, 6 out of 18 (33.3%) actively report SUD. Among housed veterans receiving assistance, 11 out of 47 valid records (23.4%) report SUD, underscoring that addiction recovery is a lifelong vulnerability requiring continuous housing retention support.

Physical disabilities affecting long-term mobility and self-care are present in 14 veterans. Sheltered veterans exhibit a notable rate of physical disability (2 out of 6, or 33.3%), reflecting an aging sheltered population utilizing emergency beds as temporary medical shelter. Additionally, 6 unsheltered veterans and 6 housed veterans manage permanent physical disabilities. Long-term chronic medical illnesses affect 8 veterans, including 5 housed veterans and 3 unsheltered veterans living on the street.

Mental health conditions (excluding SUD) are reported by 9 veterans, comprising 5 unsheltered veterans, 2 sheltered veterans, and 2 housed veterans. However, national experience in veteran outreach suggests significant underreporting of Post-Traumatic Stress Disorder (PTSD) and traumatic brain injuries due to stigma or lack of formal VA diagnostic evaluations. The co-occurrence of SUD and physical disabilities among unsheltered veterans create severe compounding barriers. A veteran managing both mobility impairments and substance dependency cannot easily navigate traditional shelter rules, keep medical appointments, or maintain physical safety in encampments, placing them at extreme risk.

Key Findings

Pulling together HMIS data, field survey results, and system metrics highlights five primary analytical insights and collaborative opportunities regarding veteran homelessness in Lubbock County:

First, recognizing the prevalence of recurring homelessness among unsheltered veterans emphasizes the importance of specialized interventions. Over 72% of unsheltered veterans in Lubbock with known homelessness histories (13 out of 18 valid respondents) have experienced multiple episodes of homelessness over the past three years. This underscores the power of pairing crisis intervention with long-term supportive housing models tailored to navigate underlying structural and personal barriers and complex health needs.

Second, strengthening continuous engagement protocols can further accelerate housing progress. While 60% (12 out of 20) of unsheltered homeless veterans are currently inactive in the HMIS database for 30 to 60+ days, our successful targeted count proves that these veterans can be effectively reached. Expanding persistent outreach follow-up will ensure veterans move smoothly from initial street contact onto active housing navigation lists.

Third, harmonizing data practices across regional providers, to the greatest extent possible, presents an opportunity to enhance care quality. With 42 housed veteran records currently utilizing simplified disability reporting, establishing unified metrics will empower system administrators to better celebrate housing successes and tailor supportive care for long-term retention.

Fourth, expanding dedicated housing models for female veterans and families will address key demographic trends. Female veterans represent 20.8% of the identified veteran population, and 18.2% of all veterans maintain immediate family dependents. Embracing these insights allows local leaders to design trauma-informed, gender-specific shelter environments and expand multi-bedroom rapid rehousing options tailored for veteran families.

Fifth, coordinating specialized medical housing will uplift aging and senior veterans. Over 48% of veterans with known ages are 50 years of age or older, including senior veterans in their 70s and 80s. Connecting aging veterans with

medical respite, accessible permanent supportive housing, and assisted care options will improve quality of life while reducing emergency medical reliance across the community.

Strategic Recommendations

To harness these insights and advance Lubbock toward functional zero for veteran homelessness, regional partners have a unique opportunity to collaborate on four high-impact, evidence-based initiatives:

Operationalizing a dynamic, community-wide Veteran By-Name List (BNL) paired with a proactive re-engagement protocol offers a powerful mechanism to maintain continuous connection. Transitioning from periodic counts to a real-time list enables a bi-weekly or monthly Veteran Case Conferencing Workgroup to review individual housing pathways together. Establishing mobile outreach re-engagement targets around 25 days of system inactivity allows teams to identify hot spots, protect client trust, and streamline documentation before veterans disengage.

Expanding veteran specific low-barrier Permanent Supportive Housing (PSH) options paired with intensive, multi-disciplinary case management creates a sustainable foundation for long-term stability among unsheltered chronic veterans. Beyond HUD-VASH voucher expansion, aligning healthcare navigation, behavioral health support, and life-skills coaching ensures robust retention. Continued strengthening of partnerships with local housing authorities further opens pathways to establish dedicated veteran preferences and streamline background check waivers for non-violent justice system histories.

Establishing specialized housing pathways specifically tailored for female veterans and veteran families addresses key regional demographic trends. Expanding Supportive Services for Veteran Families (SSVF) shallow subsidies alongside non-congregate emergency housing options enhances physical safety

and dignity for female service members. Investing in dedicated non-congregate hotel or motel accommodation provides immediate protection, while targeted resources connect families with multi-bedroom rental placements and essential childcare support.

Deploying integrated street medicine and VA mobile clinical outreach teams bridges the gap between field outreach and health stabilization. Co-locating healthcare resources directly within encampments and count locations brings critical care to where veterans reside. Uniting VA Housing First caseworkers, mobile medical providers, and peer veteran outreach workers facilitate immediate on-site medical care, prescription delivery, wound care, and Coordinated Entry assessments, ultimately reducing emergency room dependence while building enduring trust.

Conclusion

The October 15–16, 2026 targeted veteran count provides a strong foundation for advancing veteran housing stability across Lubbock County. By building beyond standard general population counts, this initiative successfully illuminates clear opportunities to enhance outreach retention, streamline data coordination, and expand specialized housing support for our aging, female, and family veteran populations.

The data demonstrates Lubbock's remarkable success in permanent housing placement, highlighted by the 51 veterans currently thriving in supportive housing programs. By applying these same collaborative strengths to support the 26 veterans experiencing literal homelessness, including 20 unsheltered individuals—our community is well-positioned to achieve lasting stability for all who served.

Ending veteran homelessness in Lubbock is an achievable objective. By transitioning from fragmented, periodic outreach to a real-time By-Name List

framework, mandating rigorous system-wide data quality, expanding low-barrier Housing First inventory, and deploying integrated mobile healthcare, ECHO West Texas, the City of Lubbock, and its partner agencies can ensure that every veteran who served the nation receives the dignity of a safe, stable, and permanent place to call home.

Acknowledgments

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Appendix

Definitions

1. **By-name list** - a live, person-specific list of every individual and family experiencing homelessness in a given community populated with real-time data.
2. **Case conferencing** - routine, multi-agency meetings focused on coordinating housing placements and services for specific individuals on the By-Name List.
3. **Case management** - a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's holistic housing and stability needs.
4. **Chronic comorbidities** - refers to the simultaneous presences of severe mental health disorders and other complex health issues that create and unstable, high-risk situation requiring intensive, specialized, and sometimes 24/7 care.
5. **Chronic homelessness** - a person having a disability and has been homeless for 12+ months continuously or has had at least 4 separate occasions of homelessness in the past 3 years totaling 12+ months.
6. **Continuum of Care (CoC)** - a community-based planning body that coordinates funding, services, and housing for individuals and families experiencing homelessness.

7. **Coordinated entry** - a standardized community process that quickly identifies, assesses, prioritizes, and connects individuals and families experiencing, or at risk of, homelessness to appropriate housing and services.
8. **Crisis intervention** - immediate, short-term emergency assistance provided to individuals experiencing acute behavioral or housing crises to stabilize their situation and prevent homelessness.
9. **Cultural competence** - the ability of service providers to understand, respect, and effectively serve individuals from diverse cultural, racial, and socio-economic backgrounds.
10. **Echo West Texas** - the designated lead agency for the TX-625 CoC managing the collaborative funding application to HUD, coordinated entry, and HMIS.
11. **Emergency housing -** a housing program whose only client base are those fleeing domestic violence. These can be temporary emergency shelters, transitional housing programs, or rental assistance programs with supportive services.
12. **Functional zero** - a milestone indicating that a community has continuous, real-time data to ensure homelessness is rare, brief, and non-recurring, where the population experiencing homelessness does not exceed the community's housing placement capacity.
13. **HMIS** - a database shared by housing providers to better coordinate services for the homeless population.
14. **Homelessness prevention programs** - one time or short-term rental, or other, assistance to help persons with housing stay in their housing.
15. **Housing First** - a housing model that provides permanent housing to people experiencing homelessness without preconditions.
16. **Housing navigation** - a service designed to help individuals experiencing homelessness or housing instability secure permanent housing by assisting with identifying housing options, gathering documents, completing applications, and providing move-in support.
17. **HUD VASH voucher** - a joint program between HUD and the VA that combines Housing Choice Voucher rental assistance with VA case management and clinical services for homeless veterans.
18. **Intimate partner violence** - physical, sexual, or psychological harm caused by a current or former partner or spouse, which is a primary driver of homelessness among women and families.
19. **Low barrier** - refers to housing/shelter options that have no preconditions for entry, such as sobriety.

20. **Permanent supportive housing** - non-time-limited housing for homeless individuals or families with at least one member having a qualifying disability.
21. **Military sexual trauma** - psychological trauma resulting from sexual assault or sexual harassment experienced while serving in the military, which can significantly increase the risk of housing instability and homelessness among veterans.
22. **Permanently housed** - referring to people who are stably housed in their own apartment or house with or without a subsidy.
23. **Point in time (PIT)** - an annual count required by the Department of Housing and Urban Development (HUD). The count is an unduplicated, one-night census of sheltered and unsheltered individuals experiencing homelessness conducted by Continuums of Care nationwide. It provides a snapshot of homelessness in January.
24. **Rapid rehousing** - rental assistance used to quickly get people off the streets and into their own housing. Assistance is usually provided for 1-2 years.
25. **Shallow subsidies** - long-term, low-level financial rental assistance designed to help low-income households maintain housing stability without a full rental voucher.
26. **Sheltered homelessness** - subset of "literally homeless" persons living in shelters designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by charitable organizations or by federal, state, and local government programs. This includes those fleeing domestic violence living in emergency shelters or transitional housing.
27. **Street medicine** - the practice of delivering direct medical care to unsheltered individuals where they reside, bridging healthcare access gaps for vulnerable populations.
28. **Street outreach** - active practice of engaging unsheltered individuals directly where they live, such as on sidewalks, in parks, vehicles, or encampments, to build trust and connect them to critical care and stable housing.
29. **Supportive housing** - non-time-limited housing for homeless individuals or families with at least one member having a qualifying disability.
30. **Supportive services** - wrap-around services provided to individuals and families in housing programs, including mental health counseling, substance use treatment, job training, and life skills development.
31. **Trauma-informed housing** - an approach to housing service delivery that recognizes the widespread impact of trauma and integrates safety, trustworthiness, choice, collaboration, and empowerment into all policies and environments.
32. **Unsheltered homelessness** - is a subset of "literally homeless" persons having a primary nighttime residence that is a public or private place not meant for human habitation.

2026 Veteran Count Survey Form

Introduction & Screener

"Hi, my name is [name]. I am a veteran helping veterans. We're here working with community service providers to identify where veterans are struggling and how we can better direct resources–like housing support and healthcare–to those who have served. We aren't here to judge or report anyone; we're here to listen. This survey is confidential and won't affect any services you receive. It usually takes a few minutes. If there's a question you don't feel comfortable answering, we can skip it. Would you be able to share your experience with me today?"

Location / Cross streets / Address _____

1. **Have you already been interviewed today for the veteran count? yes / no (circle)**
    a. *If YES, thank them for their time and STOP*
2. **Are you a veteran? yes / no (circle)**
    a. *If NO, thank them for their time and STOP*
3. **What is your name or initials?** First: _____ MI: ____ Last: _____
4. **How old are you? _____ years old**
5. **What is your ethnicity?**

- American Indian/Alaskan Native
- Asian
- Black or African American
- Hispanic or Latino
- Middle Eastern or North African
- Native Hawaiian or Pacific Islander
- White
- Other: _____

6. **Where did you sleep last night?**

- Emergency Shelter
- Transitional Housing
- Hotel/Motel
- Hospital/Emergency Room
- Jail
- Car or other vehicle
- Abandoned Building/Unit or squatting
- Bus Station
- Outside (street, park, etc.)
- Friend's apartment/house
- Family apartment/house
- Own apartment/house

7. **Is this your first time being homeless? yes / no (circle)**
8. **How long have you lived in Lubbock County? _____ (circle) years / months**
9. **Are you currently receiving benefits or support through the VA? yes / no (circle)**
10. **Do you have your DD-214? yes / no (circle)**

11. **What is the biggest barrier you've faced in accessing veteran services in Lubbock?**
- Transportation
- Lack of ID/Documents
- Unsure where to go
- Past Negative experiences
- Trust
- Other:_____

12. **Do you have friends or family you are in contact with?** **yes / no (circle)**

13. **Do you have any dependents (children, etc.)?** **yes / no (circle)**

14. **Are you currently working or looking for work?** **yes / no (circle)**

15. **Have you been told you have a substance use disorder?** **yes / no (circle)**

16. **Have you been told you have a chronic health condition?** **yes / no (circle)**

17. **Have you been told you have a mental health disorder?** **yes / no (circle)**

18. **Have you been told you have a physical disability?** **yes / no (circle)**

19. **What is the one thing you need most right now to feel more stable and/or safe?**

    _____

20. **What would help you to be confident in reaching out to veteran services for help?**

    _____
    _

    _____

    _

21. **Are you willing to have someone follow up with you?** **yes / no (circle)**

22. **How can we contact you?**
    - Email: _____
    - Phone: _____
    - Regular spots:

      Location: _____

      Times: _____

Is there anything else you would like to tell me about? *(write relevant info below)*

Closing:
"Those are all the questions I have. Thank you for taking the time to share your experience. Your answers today will directly help us advocate for the resources you and other veterans need. Is there any contact information or a local service provider you'd like me to connect you with before I go?"

***Give them any supplies & service flyers available.*

Veteran Homelessness Count Strategy

Count Goal

The primary goal is to accurately measure the rate of veteran homelessness in Lubbock and the surrounding region, while determining why this population may have been underrepresented in previous counts. By leveraging the collective expertise of veterans and local service providers, we will strengthen our community's ability to identify, quantify, and assist veterans, ensuring that existing support resources are utilized as effectively as possible and identifying any need for additional services.

Phase 1: Get Started

The foundational phase focuses on establishing a leadership structure that bridges veteran service expertise with community-wide count logistics.

- **Action Item: Establish Leadership & Stakeholder Teams**
    - Form a **Leadership Team**–suggested: comprising a project manager, Continuum of Care staff, VA medical center representatives, and veterans with lived experience.
    - Convene a **Stakeholder Team**–suggested: local Veteran Service Organizations (VSOs), municipal agencies, and shelters to ensure diverse outreach connections.
- **Action Item: Initial Planning Meeting Agenda**
    - Define the veteran population scope (e.g., branch, discharge status, age ranges) to ensure inclusive data collection.
    - Discuss why count has historically underrepresented veteran population–adapt
    - Develop count methodology:
        - Street count vs counting locations
        - Veteran liaison volunteers
        - Survey development
        - Survey administration
            - Paper surveys vs app surveys

        - Script development
        - Focus groups?
    - Plan Focus groups
        - Establish recruitment plan
        - Add focus groups to timeline
    - Establish a preliminary timeline. Suggested count day between Oct 15-16

Phase 2: Plan and Identify Hot Spots

Information gathering relies on the expertise of veterans and providers to map where the population is most likely to be found and best practices to engage veterans.

- **Amended Action Items (no focus groups):**
    - Leverage existing veteran advisory boards and peer support groups to build trust and encourage participation
    - Identify “hot spots” - VA facilities, specific parks, VFW halls, and service centers
    - Gather logistical data - best times of day, safety considerations for each location, etc.
- **Action Item: Develop Outreach/Recruitment Strategy**
    - Develop questions to be asked during focus groups.
        - Survey language review
        - Hot spot mapping
        - ...
    - Create focus group recruitment flyers and language tailored to veteran networks, emphasizing the purpose of the count in improving local veteran services.
    - Leverage existing veteran advisory boards and peer support groups to build trust and encourage participation
- **Action Item: Conduct Veteran-Specific Focus Groups**
    - Hold separate focus groups for veterans and service providers to identify "hot spots" such as VA facilities, specific parks, VFW halls, and service centers and to review count specifics to better connect with, and identify, veterans.

    - Gather logistical data on the best times of day and safety considerations for each identified location.

Phase 3: Prepare for the Count

This phase finalizes the mechanics of the count and ensures all participants are trained for field engagement.

- **Action Item: Finalize Count Strategy & Logistics**
    - Select deployment sites, such as 24-hour service centers or VA clinics, that are accessible to transportation.
    - Map out specific Street Count team assignments based on the hot spots identified in Phase 2.
- **Action Item: Recruit Veteran "Guides" (Peers) and Team Leaders**
    - Recruit veteran "Guides" with lived experience of homelessness to lead data collection and survey efforts.
    - Assign Team Leaders to provide logistical support and transportation for each team.
- **Action Item: Training Protocols**
    - Conduct in-person training for Guides and Team Leaders on safety procedures and peer-led street outreach.
    - Train all volunteers on the administration of the Brief Veteran Survey to ensure data consistency and accuracy.

Phase 4: Conduct the Count

The active count period utilizes a multiple-location strategy to reach veterans in diverse housing situations.

- **Action Item: Deployment**
    - Execute the **Street Count** using peer teams to survey individuals in identified hot spots.
    - Oversee the **Organizational Count** by administering surveys at shelters, VSOs, and VA centers.

    - Staff **"Come and Be Counted"** locations at high-traffic public sites like libraries or parks.
- **Action Item: Oversee Logistics**
    - Station Team Captains at deployment sites to monitor team safety and manage the distribution of survey materials.
    - Monitor veteran hot spots and deploy volunteers from inactive sites to more active sites

Phase 5: Data Utilization

The final phase transforms raw count data into actionable intelligence for veteran service planning.

- **Action Item: Data Cleaning & Analysis**
    - Enter and clean survey data, removing duplicates based on identifying information.
    - Analyze findings to identify trends and needs.
- **Action Item: Sharing Findings & Next Steps**
    - Reconvene the Stakeholder Team to interpret results and contextualize the findings within the community.
    - Develop a strategy to share the data with funders, VA leadership, and local government to catalyze service improvements.
    - Develop a strategy that informs future non-veteran specific counts to ensure veteran representation in such counts

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Agenda

The following agenda is designed for leadership meetings. For each phase, the goal is to move from strategy to operational action.

Phase	Goal	Key Decisions Needed

1. Get Started	Establish Leadership & Stakeholders; Develop count	Who specifically represents the VA, municipal agencies, and lived-experience veterans? What should this count include in order to connect with veterans?
2. Hot Spots	Identify where veterans are and how to engage	When and where will we hold focus groups? Who runs them? What are the questions and/or focus areas for groups with the goal of engaging veterans.
3. Prepare	Train teams & finalize logistics	What are the safety protocols? When & where to meet? Who is on what team?
4. Conduct	Execute the Count	What is the 24-hour window? What are the deployment site locations?
5. Data	Analyze & Report	How will we handle data privacy/PII? Who is the audience for the final findings?

-----Key Action Items for Discussion

1. Answer - Why has count underrepresented Vets in the past?
    a. How to correct underrepresentation?
2. Define Scope - who are we counting
    a. Branch
    b. Discharge status
    c. Age ranges
    d. Housing situations
    e. What else do we want to know?...
3. Count Methodology
    a. Street vs count locations
    b. App vs paper
    c. Who will complete surveys
        i. Veterans?
    d. Survey development (refer to sample)
    e. Survey script development
    f. Count locations
    g. Recruitment plan (volunteers)

4. Focus Groups (do we need?)
    a. Focus group recruitment plan
    b. Focus groups on timeline
    c. Focus group questions & focus
    d. Who will lead focus groups
    e. Where to conduct focus groups
5. Develop timeline
    a. Proposed count day: Oct 15 & 16
    b. Requested completion of count & count report: Nov 1
    c. Things to consider
        i. Any major community events, festivals, holidays count day needs to avoid (avoid holding counts during conflicting high-traffic events)
6. Count volunteer recruitment plan
7. Volunteer Training Development (morning of count)