

**To: House Human Service Committee**

**Re 26-0766, Draft 2.1 An act relating to establishing the Vermont Homeless Response Continuum**

**2-16-2026**

This Draft Bill is moving rapidly, and I am concerned that while testimony has been taken, as it moves forward there are a limited number of voices present in the room to whom very important questions are being asked, and the answers, while given in good faith, may not represent the specific realities on the ground in all regions of the State, nor necessarily provided by shelter and care providers.

### **Context**

While homelessness is evident in all areas of the state, Chittenden County contains 25% of the State's population, and approximately **33% of the State's homeless population**.

Chittenden County contains year-round shelter beds for 169 households, or **29% of the statewide capacity of 602 households**.

COTS holds 56 overnight shelter beds for single individuals, 7 24/7 shelter beds for individuals, and 54 beds for families equating to 15 households with children, or 45% of the year-round shelter beds in Chittenden County. Additionally, we operate a Daytime drop-in center for single individuals which served 1,862 unique individuals in FY '25, approximately 85 individuals daily, the majority of whom (62%) are unsheltered.

COTS shelter services listed above cost \$2,296,421 to operate in FY '25, yet we were funded \$904,716 by the State, covering only 39% of the operating costs. I have a very real concern that as this bill contemplates a shift from grant funding to a rate payment structure that this funding will **actually decrease** if the rule making procedure restricts eligibility, increases reporting requirements, or mandates a single statewide entity other than OEO to distribute funding. **I strongly urge the Committee to maintain funding distribution within OEO as a statewide, impartial decision maker. I also urge the Committee to provide ample study time to OEO to determine how and if this shift could occur and be effective.**

75% of COTS shelter guests in FY '25 report a disabling condition, meaning mental health issues, substance use disorder, physical disability, a chronic health condition, or a developmental disability. These are the major barriers to accessing and maintaining shelter *and* housing. As a state, we need to have services for disabling conditions, and residential settings for such treatment, made widely available. I urge the Committee to consider that there is a population of unhoused individuals who will not be served by

this bill, and who would benefit from a hospital setting. See COTS testimony on 10-30-25 [here](#).

## **26-0766, Draft 2.1**

I agree in general with the purpose statement of the bill, including that the GA motel program be wound down. I would urge the Committee to schedule the ramp down of motels gradually as other options, such as those suggested in the bill, can come online.

COTS supports an expectation of engagement in services by shelter guests to the best of the guest's ability as determined by the guest and the shelter staff together. We support this expectation of engagement in services while folks stay in the motel system as part of the bill.

Under Definitions, section (22) Support Services, I want to point out that C. "Case Management" is defined earlier in the document as "individualized supports connecting households to public benefits, health care, employment, and permanent housing or other services". Currently, these services are typically known as Housing Navigation among service providers such as COTS. These are the services that we expect our shelter guests to engage in as a part of their stay in shelter. There is no definition in the draft bill for Housing Navigation, although it is listed as a service under Support Services as well.

Also under definitions, the draft bill lists (H) "navigation to other services". This definition includes the case management definitions, and referral to specialized services. I want to suggest that the Committee consider splitting out this referral section. As I testified before, and stated above, for people who are unsheltered and are experiencing disabling conditions, referrals from shelter providers are not effective, and not from lack of effort. Folks in the throes of disabling conditions are not able to access services via referral. I suggest that we empower our Agency of Human Services to be directly involved in this work, and couple section § 2207 Specialized Shelter Services to the navigation of unsheltered individuals into specialized care. I would also advocate that low barrier shelters with supportive services be considered under the definition of specialized shelters.

COTS supports the creation of AHS positions for [Care Navigators, experts in Substance Use Disorder, Mental Health Treatment, Chronic Health/Physical Disabilities, and Developmental Disabilities to work in shelter settings, especially daytime drop-in centers](#). The staff, either AHS employees or funded partners, would build relationships with shelter guests, triage need, and be capable of helping guests navigate the complex systems of care to receive the treatment they require, including admission to specialized shelters when available. These positions would satisfy the bill language in

§2207 Specialized Shelter Services for the Department to “determine the need for and develop shelter services accordingly”, while immediately addressing this need on the front line via existing systems.

To this end, I urge the Committee to work with AHS to incorporate their suggestions as [presented on 2-5-26](#) to dovetail with this bill wherever possible.

Regarding the merger of the Continuums of Care, I urge the Committee to read the statement from the Chittenden County Homeless Alliance, on whose executive committee I serve on this matter. While it may be considered, it is a complicated process that requires a deliberate approach, and coordination between the two CoC’s is possible without a merger.

Regarding the expanded use of Coordinated Entry, I urge the Committee to read the CCHA’s memo on this matter. The CE system is rather limited in scope and is simply the management of a list of names. It is not in and of itself a system of care. Resources may be better spent on replacing the antiquated Access System that is used by AHS that is used to coordinate care.

Thank you for your attention to these concerns.

Yours,



Jonathan Farrell  
Executive Director  
COTS