

Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2026 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2026 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2026 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

1A. Continuum of Care (CoC) Identification

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

1A-1. CoC Name and Number: PA-509 - Eastern Pennsylvania CoC

1A-2. Collaborative Applicant Name: Commonwealth of Pennsylvania - Department of Community and Economic Development

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Commonwealth of Pennsylvania - Department of Commu

1B. Coordination and Engagement–Accountable Structure and Participation

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

1B-1.	Accountable Structure and Participation.	
-------	--	--

In the chart below for the period from June 1, 2025 to May 31, 2026:

1.	select 'Yes' or 'No' in the chart below if the entity listed participated in CoC meetings or select 'Nonexistent' if the entity does not exist in your CoC's geographic area, and
2.	enter the number of persons on the board for each category where you answered 'Yes' in the Participated in CoC Meetings column.

You must click Save at the bottom of the form before entering the number of persons for each category where you answered 'Yes'.

	Entity	Participated in CoC Meetings	Number of Board Members
1.	Affordable Housing Developer(s)	Yes	1
2.	CDBG/HOME/ESG Entitlement Jurisdiction(s)	Yes	1
3.	Certified Community Behavioral Health Clinic (CCBHC)	Nonexistent	
4.	Community Mental Health Center (CMHC)	Yes	1
5.	Disability Advocate(s)	Yes	1
6.	Disability Service Organization(s)	Yes	1
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	1
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	2
9.	Faith-based Organization(s)	Yes	0
10.	Homeless or Formerly Homeless Person(s)	Yes	3
11.	Hospital(s)	Yes	0
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	0
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Nonexistent	
14.	Law Enforcement	Yes	1
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	0
16.	Local Government Staff/Official(s)	Yes	0

17.	State Government Staff/Official(s)	Yes	3
18.	State or Local Elected Public Official(s)	Yes	1
19.	Local Jail(s)	Yes	0
20.	Mental Health Service Organization(s)	Yes	1
21.	Mental Illness Advocate(s)	Yes	1
22.	Organization(s) led by and serving people with disabilities	Yes	0
23.	Other homeless subpopulation advocate(s)	Yes	1
24.	Other nonprofit homeless assistance provider(s)	Yes	1
25.	Other social service provider(s)	Yes	1
26.	Public Housing Agencies	Yes	0
27.	Recovery Housing or Sober Living Provider(s)	Yes	0
28.	School Administrators/Homeless Liaison(s)	Yes	0
29.	School District(s)	Yes	0
30.	Street Outreach Team(s)	Yes	1
31.	Substance Abuse Advocate(s)	Yes	0
32.	Substance Abuse Service Organization(s)	Yes	0
33.	Universities	Yes	0
34.	Veteran Serving Organization(s)	Yes	1
35.	Agencies Serving Survivors of Human Trafficking	Yes	2
36.	Victim Service Provider(s)	Yes	2
37.	Domestic Violence Advocate(s)	Yes	2
38.	Other Victim Service Organization(s)	Yes	2
39.	State Domestic Violence Coalition	Yes	0
40.	State Sexual Assault Coalition	Yes	0
41.	Youth Advocate(s)	Yes	1
42.	Youth Homeless Organization(s)	Yes	1
43.	Youth Service Provider(s)	Yes	1
44.	Other Homeless Assistance Provider(s)	Yes	1
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	1
	Other: (limit 50 characters)		
46.	United Way	Yes	1
47.	Community Foundation	Yes	1

1B-2.	Open Invitation for New Members.	
-------	----------------------------------	--

Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to invite new members to join the CoC at least annually.

(limit 2,500 characters)

In advance of semi-annual CoC meetings, new members are invited to join the CoC. This invitation is made in the save the date and registration emails, and shared when meeting agenda is distributed. Membership is established via a membership form, available year-round on the CoC website & promoted through a membership link in each CoC email. New members are added to the CoC's email distribution list (Mailchimp). Membership is frequently discussed during regional (RHAB) meetings of the CoC. Coordinated Entry (CE) regional managers engage referral partners who are also brought into CoC through CE partnership & encouraged to become members. All CoC content is posted to the CoC's website, which uses Web Content Accessibility Guidelines to make content more accessible for people w/disabilities- including appropriate alternative text for images, fully functional site using keyboard alone, & compatibility with modern screen readers. Accessible materials (PDF) are available on the CoC website. The CoC uses Mailchimp email service for communication, which provides accessible electronic formats. Zoom is used for virtual meetings, which allows for closed captioning. In-person meetings are held in accessible buildings. The CoC also honors translation & accessibility requests.

1B-3.	CoC's Strategy to Solicit and Consider Opinions on Preventing and Ending Homelessness.	
-------	--	--

Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to solicit and consider opinions regarding the CoC's general performance, strategies, and priority setting process from a broad array of individuals and organizations that have knowledge of homelessness or an interest in preventing or ending homelessness in the CoC's geographic area.
--

(limit 2,500 characters)

A) Transparent process to solicit & consider opinions on performance, strategies & priorities:
-Structure: The CoC's Governing Board, 5 Regional Homeless Advisory Boards (RHABs), standing committees (e.g., Coordinated Entry, Funding, Veterans, DV, Written Standards) & ad hoc workgroups gather input year-round. RHAB co-chairs sit on the Board, creating two-way communication between each region & CoC leadership.
-Performance: The CoC presents its annual gaps analysis & other key data at regional & semi-annual CoC membership meetings, followed by discussion of needs observed in each community. Data are published on the CoC website through interactive Tableau dashboards so anyone can review CoC-, region- & county-level data. Input is shared w/the Funding Committee to inform funding priorities.
-Priority setting: Each year the CoC solicits feedback from all grantees by email on renewal scoring criteria, & RHAB co-chairs facilitate local discussions; the Funding Committee reviews this input & approves final criteria & funding policies, which are posted publicly on the CoC website & emailed to members before scoring begins.
-Lived experience: The Homeless Action Board & Youth Action Board meet regularly, & paid PWLE seats on the Board & Funding Committee ensure system users shape decisions.
-Strategies: Semi-annual membership meetings (agendas & materials posted in advance on the CoC website) use breakout groups for in-depth feedback. CE is updated using bi-weekly operations feedback from 211, access sites, providers & people w/lived experience (PWLE); 211 conducts client satisfaction surveys after CE calls. Online surveys gather input on training needs & new initiatives. Example of input used: 211 CE hours were extended & a new CE assessment tool was developed & adopted to replace the VI-SPDAT, based on user input. Additionally, the CoC is applying for a new CE grant to fund CE Access Sites, per requests from system operators.

B) Broad array of participants: CoC members & meeting participants include homeless & victim service providers, PHAs, local & state government, health care, law enforcement, McKinney-Vento liaisons, youth serving orgs, and many more as shown on the 1B-1 participation chart.

The Eastern PA CoC's members have in depth knowledge about homelessness, best practice, the needs & priorities in their local communities, and more.

1B-4.	Public Notification for Proposals from Organizations Not Previously Awarded CoC Program Funding.	
-------	--	--

Describe your CoC's transparent process to accept and consider proposals from organizations that have not previously received CoC Program funding including faith-based organizations.

(limit 2,500 characters)

The CoC hosted a NOFO webinar on 6/23/26 to provide a high-level overview of the 2026 CoC NOFO. NOFO webinar was advertised through the CoC's email distribution system & shared through community partners. During the webinar it was indicated that new project RFPs would be forthcoming, open to all eligible orgs, & TA available to new applicants. Webinar was recorded and shared on CoC website.

New project RFP packet was released on 7/20/26. The RFP packet, posted on website & sent via email to CoC's full membership & contacts (570 people), included: RFP, due date, budget template, blank copy of application for reference, submission instructions & budget via the CoC's online survey software (Alchemer), and the CoC's scoring tool. TA was available to all applicants upon request to support submission of a competitive application. RFP stated applications would be accepted from all eligible orgs, including those that had not received CoC funding before. Application included questions about project design, goals, & budget, & experience operating similar projects. Per CoC's Funding Policies, new project applications are reviewed, scored, accepted/rejected & prioritized by the CoC's Funding Committee (FC). During the 2026 local competition, several organizations submitted applications that have not been not previously funded through the CoC. This includes: Bradford County; Schuylkill Community Action Agency; Carlisle Cares; New Hope Ministries; Lebanon Rescue Mission; Servants to All; Women's Help Center; Breaking the Barriers; and Beahive Affordable Housing Outreach, Inc. Due to the amount of funding available, the quality of the applications, & the needs of the CoC, each project was selected & is ranked on the priority listing. To support new project applicants, the CoC hosted several office hour sessions, provided guidance via email, conducted TA calls, shared resources, & more. In advance of the release of the 2026 NOFO, orgs interested in applying for CoC funding were encouraged to review the recording of the CoC's two-part new project training series. This training is a primer, designed for organizations not currently receiving CoC funding. It covers eligible project types, eligible budget line items, eligible activities, eligibility of project participants, & more.

To ensure accessibility, all trainings were presented & recorded via Zoom, w/closed caption technology available & PDF slide deck. CoC is able to provide reasonable accommodations.

1B-5	Plan for Comprehensive Strategies for Reducing Homelessness.
------	--

Describe how your CoC will incorporate comprehensive strategies for reducing homelessness, including interventions in 42 U.S.C. 11386b(d) and other targeted projects for specific subpopulations, by providing a plan to address a gap in the CoC's current homelessness system.

(limit 2,500 characters)

Gap: The Eastern PA CoC has seen an increase in older adult homelessness. Households aged 55+ represent an increasing number requesting assistance year over year, including unsheltered older adults. Many have chronic health conditions & cannot live independently w/out significant in-home support. This includes individuals who are nursing home eligible &/or ineligible but need assistance w/daily living activities. In years past, older adults w/high needs would be good candidates for Personal Care Boarding Homes or other small community-based group living residences, but in recent years the number of beds available has reduced & turnover of these beds is inadequate to meet demand.

Identification of gap: The increase of older adult homelessness is frequently reported among CoC-funded orgs & other community partners. These reports have been corroborated through the CoC's CES data, PIT data, & other sources.

Comprehensive strategies: These include (1) further data analysis, both quantitatively & qualitatively. This will allow the CoC to better understand the flow into homelessness & causes across the CoC's 33 counties. Analyze the allocation of CoC resources to seniors to determine if they receive resources at a similar rate to other vulnerable households. Determine if prevention efforts are successful. Identify barriers to accessing senior housing through PHAs, LIHTC, etc. (2) Initiate new partnerships w/ aging & senior housing providers. (3) Develop these partnerships & the joint identification of needs, barriers, goals & resources. (4) Resource development. (5) Identify immediate changes the CoC can make for impact.

Performance measures/timeline: Over the next year, (1) ID 3 new aging partnerships. (2) ID at least one pilot project & begin plan for implementation. (3) Engage the PA Interagency Council on Homelessness to support this work by encouraging aging & other system partners to participate & share ownership of initiatives. (4) Set appropriate goals for longer term strategy, to include formalized partnerships, the expansion of dedicated funding sources, identification/ implementation of additional pilot projects.

Funding sources: At the beginning, this effort will leverage the CoC's existing resources, such as street outreach, housing problem solving, Medicaid/Medicare-funded services, ESG/CoC-funded housing, as well as existing mainstream housing resources.

Oversight: The Governing Board of the Eastern PA CoC will oversee this project.

1B-5a Confirmation of Plan Coverage.

Select 'Yes' or 'No' in the chart below to indicate whether your narrative in question 1B-5 addresses the following aspects of your plan to address a gap in the CoC's current homelessness system.

1. Identifies the gap, using data or stakeholder feedback	Yes
2. The strategy to address the needs of all relevant subpopulations	Yes
3. Sets quantifiable performance measures	Yes
4. Identifies timelines for the completion of specific tasks	Yes

5. Identifies specific funding sources for planned activities	Yes
6. An individual or body responsible for overseeing implementation of specific strategies	Yes

1C. Coordination and Engagement

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

	1C-1. Treatment and Recovery Services—On-site Substance Use Treatment Availability.	
	You must upload the List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment attachment to the 4A. Attachments Screen.	
	What percent of your TH/RRH/PSH projects have substance use treatment available on site?	4%

If you are a rural CoC, describe what substance use treatment is available in your CoC and how people you serve access those services.

(limit 2,500 characters)

A range of treatment options are available throughout the CoC's 33 rural counties. These resources are primarily funded/overseen by PA Dept of Drug & Alcohol Programs (DDAP) thru 22 Single County Authorities (SCA) throughout the region. Services are provided based on American Society of Addiction Medicine level-of-care assessments, regardless of insurance type of coverage. Services include: in-patient rehab; a range of outpatient treatment options; 24/7 detox/withdrawal management; Community Residential Rehabilitation houses; halfway housing; MAT; counseling; crisis; outreach; transportation to appointments; certified peer support, as well as forensic peers; medication management and more.

There are multiple pathways for persons experiencing homelessness in CoC to connect to substance use (SU) treatment. Persons who are uninsured will begin w/ the SCA. Those w/Medicaid can access coverage through BH-MCO, of which there are 3 across the CoC.

Additionally, community-based resources provide referral, connection, & access to SUD service, including: 988; DDAP 800# hotline; DDAP's Warm Handoff program, which moves people from hospital Emrgcy Depts directly into treatment; County Asst Office; & crisis response. Several counties w/in the CoC also operate a Law Enforcement Treatment Initiative, which allows anyone to request a treatment referral from law enforcement w/no threat of arrest or prosecution.

The CoC's CE System provides Housing Problem Solving (HPS) services to HHs waiting for a housing resource. HPS includes case management, referral, & financial resource to HHs prior to housing placement. The CoC is expanding these services this year through a new CES project included on the project priority list that will help to provide CoC-wide navigation services to connect people experiencing homelessness to treatment/recovery services upon contact with the CoC vs. waiting until they are enrolled into ESG/CoC-funded project. All CoC-funded projects provide referrals to SU treatment when needed & assist program participants coordinate w/ the SCA & BH-MCO. This helps to support the coordination & integration of services across multiple systems.

1C-1a. Treatment and Recovery Services—Outpatient Treatment for Mental Health and Substance Use Disorders.

Describe how your CoC partners with, or has projects that provide, outpatient treatment for mental health and substance use disorders with a range of appropriate levels of care, psychosocial interventions, medication management, suicide prevention, and recovery supports.

(limit 2,500 characters)

CoC-funded projects provide case mngmt to support each HH's efforts to maintain housing stability & pursue self-sufficiency. This includes providing referrals and connections to outpatient treatment for MH/SUD at a range of levels based on ASAM assmt. This includes psychosocial interventions, med mngmt, suicide prevention, recovery supports & more. Some orgs provide these services through their CoC-funded projects, while most orgs provide connections & help to coordinate these services through community referrals. To provide access to a range of MH/SUD services, as quickly as possible, CoC-funded providers have partnerships w/ Single County Authority, County Behavioral Health, BH Managed Care Organizations, detox and residential care facilities, as well as providers of psych rehab providers, medication management, MAT/MOUD services, suicide prevention & crisis services, and other community-based recovery services.

CoC-organizations also hire Certified Peer Specialists (MH-focused) & Certified Recovery Specialists (SUD-focused) to support project participants. In addition, local training is frequently provided on topics such as Mental Health First Aid, motivational interviewing, progressive engagement, & more. Case managers provide support around life skills to assist individuals w/MH/SUD to maintain housing stability & recovery.

Counties also use BH reinvestment funding to develop/ expand services & supports to individuals experiencing housing needs, who also have a BH diagnosis. This includes housing programs, housing support, innovative interventions based on local barriers to services &/or housing. This partnership is especially helpful in rural counties that may lack robust services infrastructure.

Additionally, thru PA's Rural Health Transformation Plan, the CoC will benefit from statewide efforts to further expand access to MH/SUD services such as psychiatry, licensed therapists, telehealth/ remote access to treatment including medication management, expansion of Certified Peer Recovery Specialists, & increased access to inpatient care.

3 CoC-funded orgs – Lehigh Conference of Churches, Service Access & Mngmt, & Resources for Human Dev – directly provide Medicaid-reimbursable services incldg MH & SUD.

CoC is actively working on finalizing a SAMSHA MHBG-funded cross-system toolkit that gives providers referral pathways by need & insurance status, BH-MCO/SCA contacts by county, co-occurring guidance & a 42 CFR Part 2 data-sharing protocol.

1C-1b. Treatment and Recovery Services—Peer Support and Recovery Navigation.

Describe how your CoC partners with, or has projects that provide access to, peer recovery specialists or other forms of peer support and recovery navigation.

(limit 2,500 characters)

100% of CoC-funded projects provide access to peer support services through the behavioral health system of which are widely available as a Medicaid billable service.

Peer support is provided to individuals receiving street outreach services, in shelter, already in housing, remotely via telehealth, etc. Peer supports are also available through drop-in centers, Clubhouses, & other recovery-focused providers in the community.

CoC-funded organizations are also funded with PATH in 11 of the CoC's 33 counties. These PATH programs also provide outreach-based access to peer support specialists.

There are multiple forensic-based housing and/or recovery programs w/in the CoC's geographic area, many of which provide access to forensic peer specialists.

Many CoC-funded projects have certified peers on staff to support project participants. CPS/CRS staff often supplement the work of case managers to support client needs.

Lehigh Conference of Churches, a CoC-funded provider in the Lehigh Valley, currently employs a total of 8 Certified Peer Specialists & Certified Recovery Specialists to support program participants. The Center for Community Action, which serves 9 counties across the CoC, employs a Certified Recovery Family Specialist, a peer support professional who uses their lived experience supporting a loved one through SUD to help other families navigate the recovery process.

Pennsylvania's Rural Health Transformation Plan also includes the expansion of educational awards to help increase training & certification of CPS/ CRS staff. The goal of this effort is to expand employment opportunities for CPS/CRS & to increase timely connection to support when individuals are transitioning between levels of care in the BH system.

1C-1c. Treatment and Recovery Services—Connecting Individuals Experiencing Serious Mental Illness with the Services Necessary to Promote Stability.

Describe how your CoC identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as Assertive Community Treatment teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment.

(limit 2,500 characters)

The CoC identifies individuals w/Serious Mental Illness (SMI) at multiple points. Street outreach teams, & SAMHSA-funded PATH workers in 11 of the CoC's counties, conduct outreach & assessment of individuals who are unsheltered. Additionally, all households seeking homeless assistance are assessed through CE. The CE assessment tool includes questions related to disabling conditions, including SMI. This information is used to make connections & referrals to community-based services.

SMI diagnosis is also used to support CE referrals to providers operating projects specifically for individuals w/SMI, for example, PSH projects operated by Fitzmaurice Community Services and Resources for Human Development, both operating in Monroe County.

To enhance the connection to immediate supports, the CoC has submitted a new CES project application included on the priority listing that will provide navigation support to enhance immediate connection to MH/SUD services that begins once initial contact is made with the CoC.

All CoC-funded providers are expected to provide services or referrals for services to support the behavioral health needs of project participants. This includes referrals to inpatient, outpatient, and recovery services. Referrals are also made for Intensive Case Management and Blended Case Management, both of which are available in each county throughout the CoC. Some CoC-funded projects, including those operated by organizations that bill for Medicaid reimbursable services, provide ICM-level support to SMI program participants, as needed.

In communities w/ formal street outreach programs, ICMs and/or PATH workers will often be part of the outreach team. Additionally, many of the counties across the CoC have mobile crisis services available. There are nine ACT teams operating across 8 counties within the CoC's geographic area. Coordination, referral, & service delivery of ACT services are reserved for the most complex individuals to provide to help prevent hospitalization.

Individuals w/SMI who are also in need of homeless/housing assistance are also referred to the CoC through county BH offices, psychiatric & crisis unit discharges, jails, Mental Health & Drug Courts, schools, community providers, & more.

1C-1d. Treatment and Recovery Services—Coordination with Providers in Connection with Drug or Other Specialty Courts.

Identify at least one partnership the CoC has with a provider or entity providing services in connection with Drug Courts and other specialty courts serving individuals with mental and substance use disorders, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment.

(limit 500 characters)

There are a number of Drug Courts, MH Courts, BH Courts, & other problem-solving courts throughout the Eastern PA CoC. Many CoC-providers partner w/ these courts to support the housing needs of court participants. The Lehigh County Drug Court engages the Lehigh Conference of Churches (CoC-funded organization & CoC member), which is under contract with Lehigh County Gov, to provide housing assistance to court participants. Participants are also supported with MH/ SUD services.

Describe how your CoC coordinates with the provider or entity identified above to support housing stability and movement towards independence, including by leveraging court orders.

(limit 2,500 characters)

The Lehigh Conference of Churches, a CoC-funded grantee and CoC member, works to provide housing stability to participants of the Lehigh County Drug Court. Lehigh County Government contracts with Lehigh Conference of Churches to provide Drug Court participants with short-term housing assistance (up to 6 months) for rehousing or homelessness prevention, plus Intensive Case Management focused on behavioral health and substance use recovery. This work also includes representatives from the County's Forensic Team, Probation/Parole, among others. Lehigh Conference of Churches operates several housing and homeless assistance programs utilizing CoC, ESG, county funding, and more. This experience has resulted in increased housing stability among Drug Court participants.

Court orders are focused primarily on restricting drug use and preventing relapse. Lehigh Conference of Churches is able to leverage these court orders through to support housing stability. When issues arise - typically by the landlord complaining to the housing provider about the tenant, or a neighbor complaining to the case manager during a check in, or a case manager seeing something while meeting with the participant within their home - Lehigh Conference of Churches is required to report this information to Probation/Parole.

This partnership leverages county justice and behavioral health funding to house and stabilize Drug Court participants outside the CoC Program, expanding the total housing resources available in Lehigh County. Participants receive assistance matched to their needs and court involvement, while CoC-funded RRH and PSH remain available for households with no other path to housing.

1C-1e. Treatment and Recovery Services—Partnership with Local Crisis System of Care.

Identify at least one partnership the CoC has with the local crisis system of care including 988 and crisis contact centers, mobile crisis and outreach services, and crisis stabilization services.

(limit 500 characters)

CoC helps connect individuals in crisis w/ support thru Connect To Home, the CoC's CE System. Connect To Home operates through calls & texts to PA-211 & community access sites. Anyone in need of a connection to crisis services can contact 211 or enter a walk-in site to be directed to the crisis services available in their local community &/or 988. When the call center is closed, the United Way/ PA-211 website directs individuals in crisis to call 988 & has a searchable database on the website.

1C-1f.	Treatment and Recovery Services—Availability of Units for Persons Reporting Chronic Substance Use.	
--------	--	--

You must upload the List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment attachment to the 4A. Attachments Screen.

Identify the number of CoC Program-funded units that require program participant engagement in substance abuse treatment services as a condition of continued participation in the program in accordance with 24 CFR 578.75.	29
--	----

1C-1g.	Treatment and Recovery Services—24/7 Access to Detox, Residential, or Inpatient Treatment.	
--------	--	--

Is there 24/7 access to detox, residential, and inpatient behavioral health treatment within the geographic area of your CoC?	Yes
---	-----

1C-1h. Treatment and Recovery Services—Formal Partnership with Behavioral and Mental Health Facilities.

Identify at least one formal partnership the CoC has with a Certified Community Behavioral Health Clinic (CCBHC), Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GBHI) provider, or a similar facility if none of the above are located in the geographic area.

(limit 500 characters)

There are 9 PATH-funded providers operating in 11 counties throughout the Eastern PA CoC. These providers conduct outreach and provide resources and navigation support to individuals with SMI. PATH services, which operate in some of the CoC's most rural communities, helps to expand supports to some of the hardest to reach/engage in the community, connecting these individuals to housing/supports available through the MH system & CoC. PATH providers enter program data is entered into PA-HMIS.

1C-1i. Treatment and Recovery Services—Sober Housing Availability.

Identify at least one new or existing CoC Program-funded project that operates sober housing in accordance with 24 CFR 578.93(b)(5).

(limit 500 characters)

The CoC has included the Schuylkill Community Action's Bridge House TH project on the new project priority listing this year. This project incorporates supportive service participation sobriety requirements that are individualized based on each participant's goals & needs. Participants are expected to maintain weekly case mngmt contact, engage in their housing stability plan, meet applicable work/community service requirements, and remain drug- and alcohol-free while at Bridge House.

1C-1j. Treatment and Recovery Services—Warm Hand-Offs to Stable Housing Providers.

Describe how your CoC coordinates with the programs named in questions 1C-1a through 1C-1i to facilitate warm hand-offs to stable housing providers and prevent entry into homelessness.

(limit 2,500 characters)

The CoC coordinates w/treatment & recovery partners through Coordinated Entry (CE) and case conferencing meetings. CoC members also participate in county-level workgroups that focus on high need/ complex cases. These meetings include reps from Single County Authorities (SCAs), county MH offices, PATH providers, crisis teams, & others. Each SCA maintains a DDAP-required warm handoff policy moving overdose survivors from the ER directly into treatment. Housing planning can begin while the person is still in care. CE access sites accept referrals from detox, residential, inpatient, & crisis stabilization programs before discharge if individual was homeless at entry. While referral does not guarantee immediate access to housing at discharge, CoC-funded orgs participate in meetings w/SCA to identify alternatives such as Long-Term Structured Residences, CRR, DDAP-licensed recovery houses, or other treatment/recovery focused option until housing is available. Treatment courts also have access to some emergency/short-term housing resources that are allocated in coordination with CoC-funded providers, who help to coordinate appropriate services through warm handoffs. Where available, street outreach teams include PATH funded staff who will remain involved with an individual until warm hand off to housing providers can occur. Individual counties have informal and formal agreements, including MOUs, across community partners to establish & support coordination and warm handoffs. One example comes from Centre County Adult Services (a CoC-funded org) which has MOU in place w/ local treatment center to coordinates services, including warm handoff, for individuals w/ SUD. Adult Services also has a Letter of Agreement in place w/ BH provider around procedures for sharing info about clients to best coordinate services. In addition, Adult Services participates on local committees that help to enhance cross-system coordination of services, including Re-Entry Coalition, Criminal Justice Advisory Board, and County Mental Health Provider Meeting.

1C-2. Supportive Services Investment.

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$30,175,685
2. Of projects your CoC proposed to be funded in the FY 2026 CoC Program Competition, enter the total amount of funding for the supportive services budget line items.	\$13,433,396
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	45%
4. Enter the amount of funding, leverage, match, and funding commitment from other formal partnerships in supportive services for the projects included in your CoC's FY 2026 ARD.	\$5,829,675

5. Percent of your CoC's FY 2026 ARD (from element 1 above) that is the supportive services funding in proposed projects (from element 2 above) plus the amount of funding, leverage, match, and funding commitment from other formal partnerships in supportive services (from element 4 above).	64%
---	-----

1C-3.	Participation Requirements for Supportive Services.
	You must upload the Language from Project Supportive Service Agreements attachment to the 4A. Attachments Screen.

What percent of your housing projects (TH, PH-PSH, PH-RRH, and Joint projects) require program participants to take part in supportive services (e.g. case management, employment training, substance use disorder treatment) in line with 24 CFR 578.75(h)?	100.00%
--	---------

1C-4. Consulting with ESG Recipients.

Describe how your CoC has and will continue to consult with ESG recipients in the planning and allocation of ESG funds.

(limit 2,500 characters)

State ESG: DCED is the State ESG Recipient and the CoC's Collaborative Applicant, and holds seats on the CoC Gov Board, Gov Committee & Funding Committee, which results in coordinated CoC & ESG funding decisions. All 33 counties are eligible for State ESG, however non-entitlement areas historically receive priority for State ESG. The City of Allentown & Northampton Co (Lehigh Valley) are the CoC's only direct entitlements.

Each year DCED updates its ESG method of distribution through its Annual Action Plan, which sets funding priorities & the allocation plan and is open for public comment. The CoC shares comment opportunities & meetings w/ its membership. DCED also engages CoC membership in Con Plan input, including community needs & priorities for CDBG, HOME, ESG, HTF & HOPWA. DCED also represents the CoC's needs & priorities on PA's new Interagency Council on Homelessness.

DCED requires ESG subrecipients to participate in CoC planning, follow CoC Written Standards, use Coordinated Entry & attend CoC-sponsored training. ESG applicants must provide a CoC letter of support. Regional ESG projects are incentivized to fill service gaps, support smaller/rural counties that lack capacity to apply directly & shift resources in real time where needs emerge. DCED uses HMIS performance data to evaluate projects. The CoC facilitates quarterly monitoring of CoC & ESG projects' performance & data quality, strengthening SPM, LSA & CAPER data. The CoC's annual gaps analysis uses CES data (LOT to PH, % households served, PH turnover) & HIC data to ID needed resources. The CoC shares this analysis, plus county, regional & CoC-wide PIT/HIC data, with all ESG recipients.

Local entitlements: Allentown & Northampton Co each seek consultation & approval of their ESG allocation plans from the Lehigh Valley RHAB, one of the CoC's five regional bodies. ESG coordination with these jurisdictions happens mainly at the RHAB level. Both require HMIS participation, CoC Written Standards & CES. Lehigh Valley providers & community leaders sit on the CoC Gov Board & Funding Committee, which keeps information & capacity needs flowing between jurisdictions.

1C-4a. Coordination with Emergency Shelter Providers.

Describe how your CoC coordinates with shelter providers to connect individuals and families with CoC assistance.

(limit 2,500 characters)

The CoC coordinates and partners with emergency shelter providers in a number of different ways to connect households w/CoC assistance. Shelters across the CoC:

- submit data annually to support the CoC's HIC/PIT submissions.
- operate CE access sites, conduct CE assessments, attend case conferencing meetings, support documentation requests for enrollment into CoC-funded projects.
- coordinate w/ CoC providers at regional & CoC-wide meetings. Shelter providers are invited to attend CoC-sponsored training, which includes annual fair housing, safety planning, updates on mainstream benefits, & more.
- coordinate w/M-V school district homeless liaisons, ensuring children's transportation needs are addressed.
- coordinate w/treatment & recovery providers, including providing meeting space so outside service orgs can meet w/shelter residents on site.
- coordinate w/local CoC-providers when the needs of a household are not able to be met by the shelter.
- seek out hotel/motel vouchers, or other resources to provide emergency housing to complex households that are not appropriate for shelter.

ESG-funded shelters are required to participate in HMIS. The CoC encourages HMIS participation by all shelter programs & provides HMIS licenses & training to all participating orgs. Shelters in need of renovations, including to increase accessibility, privacy, etc., are encouraged to apply for ESG funding.

1C-5. Data Sharing to Inform the Homelessness Response System.

Describe how your CoC has or will share PIT, HIC, HMIS, and System Performance data with state and local government as permitted by law in order to inform the homelessness response system.

(limit 2,500 characters)

The CoC shares data consistent with the PA HMIS Privacy Notice, Security Plan & client consent, which permit release of de-identified, aggregate data for planning, performance & funding. Client-level data is released only as the Privacy Notice & law allow (e.g., signed consent, legal requirement, court order). VSP data stays in comparable databases per VAWA and is not covered by the PA HMIS Privacy Notice.

The HMIS Governance Charter, Privacy Notice, privacy plan, & security plan for PA-HMIS are kept up to date by the PA HMIS Joint Advisory Committee, which brings together HMIS users & system leaders from the 4 CoCs that jointly participate in PA-HMIS. The system also includes statewide PATH & veterans data.

PA DCED is the CoC's Collaborative Applicant, HMIS Lead & State ESG recipient, & as such have direct access to all HMIS, PIT, HIC & SPM data to inform state ESG allocations & the Con Plan.

Annually, the CoC gives county-level PIT & HIC data to all Con Plan jurisdictions, incl. Allentown and Northampton County (local ESG recipients).

This data is also made available to inform the resources & needs of local jurisdictions who are completing Comprehensive Plans.

HIC, PIT & (aggregate) CES data are also used to inform the CoC's annual gaps analysis. The data & conclusions of the analysis are provided online via a Tableau dashboard & made publicly available. This information is pushed out to the CoC membership. This data is also used by the CoC's Funding Committee to inform where additional resources are needed.

1C-5a. Using Other Data Sources Alongside HMIS to Improve Care.

Describe how your CoC utilizes other data sources alongside HMIS to improve care (e.g., health care utilization and claims data, electronic health care record data; admission, discharge, and transfer data; and law enforcement and corrections system data).

(limit 2,500 characters)

The CoC, through a YHSI grant, is currently engaged in two data projects of relevance.

1) Youth system data matching: Cross-system data matches and/or data integration between different data systems (e.g. homeless response system, education, human services, etc.) will be conducted to better understand the various pathways into homelessness experienced by youth and young adults in an effort to improve intervention efforts and the targeting of resources.

2) Cross-systems Needs/Gaps Analysis: Following step 1 (above), analysis of cross-system data will support the identification of system-level needs/gaps, a YHSI pilot project, and CoC-wide planning.

In addition to the YHSI-related work, PA DCED and PA DHS are collaborating to utilize HMIS data to evaluate Bridges to Success: Investments in Health, a Section 1115 Medicaid demonstration program. This will include housing interventions and supportive services that connect people with primary care, mental health/ substance use disorder treatment, and recovery supports can decrease avoidable emergency room use or hospitalizations. Housing stability services will be eligible, with HMIS being a data source used to determine outcomes and effectiveness.

HMIS coordination with PA Navigate is also underway. This will provide closed loop referrals as part of the Medicaid waiver program.

1C-6. Employment and Workforce Development Partnership.

Identify at least one partnership the CoC has with employment and workforce development programs and organizations such as the Local Workforce Development Board, State Workforce Agency, American Job Center (also known as One-Stop Career Centers), registered apprenticeship program, community and technical college, union training program, adult education provider, or State Vocational Rehabilitation agency.

(limit 2,500 characters)

The CoC closely partners with the 13 Community Action Agencies (CAAs) that operate within the geographic area. These CAAs operate a employment and workforce development throughout the CoC. For example, the Central Susquehanna Opportunities (CAA) operates CareerLink in 9 counties. The services CAAs provide to support employment efforts include: transportation; childcare; clothing/uniforms; flexible funding to support licensing fees; and more.

Tableland Services, Inc. (CAA) provides an wide array of services to address the needs of Adult & Dislocated Workers, as well as Young Adults. Additionally, because CAAs often provide a range of services – child care; rent assistance/ housing support; Representative Payee; Financial Literacy; GED prep; transportation services; food banks; and more – most program participants are able to resolve barriers to employment.

In addition to the CoC's partnerships with CAA's, many CoC-funded organizations partner with PA CareerLink, One-Stop & PA OVR programs for skill building & job placement. Examples of partnerships include: formal cooperation agreements w/ their local CareerLink offices & refer participants; provide office space for workforce development programs to provide on-site support; directly provide employment training, job development, supported work, & transportation assistance.

The CoC's Governing Board includes three CAA representatives from different counties/organizations that oversee employment programs & help to guide CoC strategy regarding helping participants access employment and workforce development programs.

1C-7. Street Outreach—Cooperation with First Responders and Law Enforcement.

Describe in the field below how your CoC's street outreach projects (including co-response) cooperate with first responders and law enforcement to increase positive interactions in order to increase housing and service engagement and promote use of CoC services.

(limit 2,500 characters)

CoC providers operate street outreach (SO) projects, funded by ESG, CoC, SSVF, PATH, VA & other resources. SO teams cooperate/partner w/law enforcement (LE) regularly. SO does not interfere w/ the work of LE, but instead, assists LE & first responders in engaging people who are unsheltered, when appropriate & safe.

Given the vast rural nature of the CoC, local LE is often the first contact w/an unsheltered household. LE serve as a referral source for SO teams. In many situations, SO teams partner w/local LE when conducting outreach and/or engaging unsheltered persons. This includes LE, state police, first responders, & park/forest rangers.

SO teams conduct CE assessments & enrollment to increase housing/service engagement. Households enrolled in CE are eligible for immediate assistance through the CoC's flexible housing problem solving initiative, as well as through local county/organizational-level resources.

Examples of SO/LE cooperation within different communities of the CoC include:

- Co-responder with Officers present to address any safety concerns while SO & behavioral health staff lead engagement, offering shelter, treatment, transportation, etc.
- Based on MH First Aid concept, MH workers provide referrals & warm handoff to SO.
- Crisis Intervention Team trained officers that support SO
- Mobile crisis that train local LE around appropriate engagement.
- Cross-system training & information about available resources
- LE can access 211 for real-time referral to shelter. In addition, PA DDAP has 24/7 help line & supports warm handoffs to treatment after an overdose.

1C-8. Family or Support Network Reunification.

Describe how your CoC, or your recipients, assist with family or support-network reunification efforts for individuals experiencing homelessness or living in CoC Program-funded housing (e.g., case management, travel costs, arrangement of assistance in another geographic area).

(limit 2,500 characters)

For individuals experiencing homelessness, the CoC provides housing problem solving (HPS) resources to address housing needs immediately, versus waiting for a CoC/ESG resource. HPS includes light touch case mngmt services, as well as funding for direct client asst, which can include reunification to family &/or community of origin where the individual/ household (HH) has a support system. The CoC does not currently track the outcomes for reunification but will look to track this as a standalone destination moving forward. HPS resources can cover the cost of travel, among other support.

The CoC also uses HPS to provide incentives/resources to the friends/family to individuals experiencing homelessness to facilitate reunification, when possible. This may include gift cards for groceries, for example, to help offset the financial impact of additional HH members.

For HHs who are in shelter or unsheltered, but have income, the CoC's HPS can provide financial assistance for a rapid exit out of homelessness. This one-time assistance with first/last/security payment &/or housing search assistance. The CoC's Written Standards direct emergency shelter providers to engage in problem solving conversations with households prior to shelter entry (unless fleeing DV), which includes trying to identify opportunities to stay with friends or family if possible, rather than shelter.

The CoC, in partnership with local PHAs, also uses FUP vouchers to support family reunification efforts. FUP vouchers are in use in five counties. Local CoC providers coordinate across systems w/in their county to leverage resources, funding & case management support to assist HHs thru homelessness prevention and reunification efforts.

In situations where the system does not have a resource to support an individual to reconnect with family/ support networks, many providers work with local churches to fill this gap. These churches can provide cash and/or volunteers to help meet a specific need.

Valley Youth House works to support reunification efforts among youth enrolled in their programs. This may take the form of enhancing their support network or returning/reconnecting to their families when possible.

Providers report that when an individual has been in PSH & addressed MH & addiction, they begin to reconnect with friends & family members, which can lead to program exit and family reunification.

1C-9	Partnering with Public Housing Agencies—Agreement to Enable Transition to HUD Assisted Housing.	
	Does your CoC have an agreement with at least one public housing agency to enable participants to transition from Transitional Housing, Rapid Re-Housing, and Permanent Supportive Housing to HUD assisted housing?	Yes

1C-10. Protecting Public Safety—Cooperation with Law Enforcement.

You must upload the Evidence of Coordination and Non-Interference with Local Efforts to Advance Protecting Public Safety attachment to the 4A. Attachments Screen.

Describe how your CoC cooperates and does not interfere with or impede local efforts to advance the objectives below, and assists first responders in providing services to homeless individuals.

(limit 2,500 characters)

The Eastern PA CoC cooperates w/local governments, law enforcement (LE), & first responders & does not interfere with or impede local public safety efforts regarding clearing tents & encampments, decreasing the public illicit drug use, utilizing standards for commitment, & sharing information in accordance w/SORNA. The CoC actively assists first responders in connecting people experiencing homelessness to shelter, treatment, and housing.

Cross Training. On July 26, 2026, CoC staff collaborated on a 3-hour session, "How Local Policies Shape Police Response to Homelessness," at the Homes Within Reach Conference, PA's largest housing conference. Panelists included a police training specialist, the Eastern CoC Coordinator, a Mechanicsburg police lieutenant, & a Lancaster police social worker. The session covered co-response models, police-provider partnerships, police policies for assisting people experiencing homelessness, and new police trainings on homelessness. A follow-up session is currently being planned for the next conference.

Co-Response & Coordination. Multiple regions of our CoC (e.g. Lehigh Valley, Bethlehem, Cumberland) operate co-response initiatives & partner w/police on encampment resolution strategies. Mental health & homeless service providers regularly coordinate & co-respond w/LE to help address the acute needs of unhoused individuals. A focus of this collaboration is to provide trauma-informed de-escalation & appropriate interventions for those experiencing SUD/SMI &/or who are a danger to themselves/others. CE regional managers have conducted ride alongs w/local police to identify strategies for strengthening the CES to respond to concerns police have seen on the ground. Local LE also assists w/CoC's Point-in-Time Count, which has helped to promote effective count coverage. Valley Youth House (VYH), a CoC- & RHY-funded youth services provider, has an MOU w/Allentown Police Department (APD) outlining how VYH & APD will work together to address unsheltered youth experiencing homelessness through identification & referral process.

Encampment Strategies. The CoC has contracted with the Housing Alliance of PA to develop CoC-wide encampment best practices. The information-gathering process draws on input from LE & first responders, including lessons learned from a recent encampment closure within the CoC. A planned deliverable of this initiative is to develop practical resources and training needs for LE.

1C-10a. Protecting Public Safety—Plan to Quickly Clear Tents and Encampments.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to quickly clear tents and encampments on public property and connect individuals who are camping in public with appropriate services and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

The majority of encampments w/in the CoC are located in more urban areas, such as the Lehigh Valley, Cumberland, & Monroe Counties. In the last 2 years, Bethlehem & Allentown (in Lehigh Valley) made significant efforts to increase encampment clearings & improve encampment response strategies. In Allentown, city officials increased efforts to clear large encampments, such as Jordan Creek & Fountain Park. Safety concerns, flood risks, & no-trespass laws were leveraged by the city to justify clearings. Allentown's approach was effective in facilitating relocation of 100+ individuals in the past year. The Allentown Mayor & City Council have debated formalizing the encampment closure process & codifying the operational procedures in a city policy or council ordinance. Disconnects regarding appropriate & effective strategies for mitigating unsheltered homelessness led to delays but encampments were removed in early 2026.

Bethlehem has leveraged City Ordinance 941.02(a)(4) prohibiting tents/temp shelters on City park property & no-trespass laws on private property (e.g. Norfolk Southern). A strong practice in Bethlehem has been ongoing collaboration from city health officials & the Community Connections program, who helped coordinate outreach on-site for the Norfolk Southern encampment. Health officials assessed safety concerns (encampment's proximity to active rail lines), & presence of open fires & improper waste to justify the closures. Bethlehem ES program was stationed on-site before deadline to connect individuals w/TH or temp hsg options. City coordinated efforts w/regional orgs like New Bethany Inc., Lehigh Conference of Churches, & the local Street Medicine team.

These challenges/successes in Allentown and Bethlehem have prompted the CoC to contract w/Housing Alliance of PA to develop a CoC Encampment Strategy w/protocols, standards, & toolkits. The intended deliverables from this contract will ideally equip cities/counties w/in the CoC w/effective strategies & legal/policy mechanisms to implement successful, intentional encampment closure. Input will be gathered from a variety of stakeholders involved in prior closures to promote continuous quality improvement. The CoC will also work w/local communities to further research encampment circumstances across the region & evaluate the effectiveness of various interventions in ensuring encampment closures lead to effective service/housing connections.

1C-10b. Protecting Public Safety—Current Status of Tents and Encampments.

Describe the current status of tents and encampments in the CoC's geographic area.

(limit 2,500 characters)

The Eastern PA 2026 PIT count found 529 unsheltered people in 414 households, comprising 31% of the 1677 total people counted. The Eastern Pennsylvania CoC covers 33 primarily rural counties, so the nature of unsheltered homelessness varies widely across the region. In most rural counties, homelessness is generally dispersed, and there is minimal visible homelessness. Many unsheltered individuals reside in vehicles, abandoned structures, wooded areas, etc., rather than concentrated in large visible encampments. Tents and encampments are more visible in our larger population centers, particularly in the Lehigh Valley, along with Monroe and Cumberland Counties. The Lehigh Valley region alone had 228 individuals experiencing unsheltered homelessness. CoC staff, street outreach providers, and law enforcement estimate that there are currently approximately 15 encampments of 10 or more people within the CoC, the vast majority located in the Lehigh Valley. This estimate fluctuates as local governments close and disperse emerging camps. In 2025, the CoC worked with municipalities, first responders, and service providers on major encampment closures in the Lehigh Valley, including sites in Allentown and Bethlehem. This effort resulted in the relocation of approximately 200 people. Unfortunately, the number of unsheltered people in the Lehigh region increased between the 2025 and 2026 PIT Counts, indicating a significant need for comprehensive strategies to target unsheltered homelessness and encampments. The CoC has since engaged the Housing Alliance of PA to develop protocols, standards, and toolkits for the Eastern PA CoC Encampment Strategy. This effort will work to improve and expand on the Lehigh Valley encampment response initiative. Findings from stakeholder input, process mapping, and intervention outcomes will be translated into comprehensive toolkits, protocols, and standards. Strategies will be adapted for use in small- and mid-size communities to ensure rural counties within the CoC are also well equipped to manage public camping.

1C-10c. Protecting Public Safety—Plan to Decrease the Public Use of Illicit Drugs.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to decrease the public use of illicit drugs and quickly connect individuals who are using illicit drug in public with appropriate services and/or law enforcement and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

Laws/Practices/Policies: The Controlled Substance, Drug, Device, and Cosmetics Act (35 P.S. 780-113.7) is the primary state law regulating the use and possession of illicit drugs and drug paraphernalia. 18 Pa.C.S. § 5503 is Pennsylvania's law addressing public intoxication, which prohibits individuals from being under the influence of alcohol or controlled substances in a public place who pose a danger themselves/others/property or annoy people in the immediate vicinity. These laws help regulate public illicit drug use in every county within the CoC and offer a mechanism for law enforcement interventions. Many CoC counties feature strong partnerships between law enforcement, justice systems, behavioral health clinicians, and CoC providers, which offer an effective mechanism for promoting connections to SUD treatment and housing interventions.

For example, the Lehigh Conference of Churches (LCC, a CoC-funded organization & CoC member) street outreach team accepts referrals from, and coordinates with, police in Allentown, Bethlehem, and Easton. Additionally, the Lehigh County Drug Court engages the LCC, which is under contract with Lehigh County Gov, to provide housing assistance to court participants. Participants are also supported with MH/ SUD services. By leveraging laws prohibiting public illicit drug use through mechanisms like Drug Courts, those who use illicit drugs in public can be diverted to housing programs for more intensive supports.

Data: In the 2026 PIT Count, 39 of 514 unsheltered adults were experiencing a SUD (7.6%). This was a decrease from the 2025 PIT Count which indicated 12.5% of unsheltered adults experiencing a SUD. This data shows promising progress in reducing the proportion of people experiencing SUD in unsheltered settings.

Plan: The CoC will further this progress by continuing to encourage and train counties, providers, and law enforcement entities in the region to develop collaborative strategies to address the intersection of SUD and unsheltered homelessness. The CoC is pursuing additional funding to expand the number of transitional housing, sober living, and substance use treatment beds to effectively close gaps in service offerings for individuals experiencing SUD who are unsheltered. The CES will work to increase referral pathways between police, first responders, courts, and jails to leverage available units/services to address gaps in diversionary and discharge options.

1C-10d. Protecting Public Safety—Current Status of Overdoses and Illicit Drug Use in Public Spaces.

Describe the current status of overdoses and illicit drug use in public spaces in the CoC's geographic area.

(limit 2,500 characters)

The Pennsylvania Department of Health Office of Drug Surveillance and Misuse Prevention monitors overdose statistics for every county within the state. Data from September 2026 indicates a total of 4,117 overdose victims within the counties that comprise the Eastern CoC. Overdoses within the CoC region maintained a 70% survival rate. Naloxone was successfully administered in 51% of total overdoses. State data indicates that 54.5% of overdose deaths occur within the decedent's own home. Current reporting does not specify the proportion of overdoses that occurred in public settings or among people experiencing homelessness. The CoC will engage the state to further research overdoses among unhoused individuals to identify potential gaps within the service continuum and leverage effective strategies to coordinate treatment interventions and overdose prevention initiatives.

In the 2026 Eastern PA PIT Count, 39 of 514 unsheltered adults were experiencing a SUD (7.6%). This was a decrease from the 2025 PIT Count which indicated 12.5% of unsheltered adults experiencing a SUD. This data shows promising progress in reducing the proportion of people experiencing SUD in unsheltered settings. According to the 2026 Housing Access Among People Who Use Drugs in Pennsylvania Report, chronic substance abuse among unsheltered individuals has declined state-wide since 2016, from 23.1% (n=3,542) to 17.2% (n=2,422) in 2024.

1C-10e. Protecting Public Safety—Standards to Address Danger to Self or Others.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to utilize standards that address homeless individuals who are a danger to themselves or others (e.g., involuntary commitment) and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

Pennsylvania's Mental Health Procedures Act (MHPA), including Section 302, provides a pathway for emergency involuntary examination when an individual presents a clear and present danger to self or others because of severe mental illness. This is an important tool within PA, but its 120-hour limit can create a gap between crisis stabilization and the longer-term housing and behavioral-health supports needed to prevent recurrent homelessness. The challenge is particularly significant across the CoC's 33 largely rural counties, where access to specialized behavioral-health services and transportation can vary substantially.

The 2026 PIT Count identified 1,677 people experiencing homelessness, including 369 adults with serious mental illness and 106 adults with a substance use disorder. There is not specific data collected regarding the proportion of people experiencing homelessness who might be a danger to themselves or others. Co-response providers, behavioral health clinicians, and law enforcement across the state have noted that many unhoused individuals who are subject to involuntary commitment often return to the streets after the 120-hour limit due a lack of effective and available interventions at the time of discharge.

The CoC will leverage the MHPA by strengthening referral and coordination protocols between CES, street outreach, behavioral health clinicians, crisis/co-response providers, hospitals, law enforcement, and housing providers. The CoC will work to strengthen written standards and cross-training regarding assessing and pursuing involuntary commitments. The CoC will use its five Regional Homeless Advisory Boards to develop county-level crisis-response pathways that are targeted for each community and effectively coordinate with local Assertive Community Treatment and co-response teams.

To mitigate the limitations of the 120-hour period of Section 302, the CoC/CES will engage psychiatric facility discharge planners to develop targeted strategies and resource prioritization during the critical 120-hour window for individuals subject to involuntary commitment who are at risk of returning to homelessness. The CoC/CES will convene relevant stakeholders to identify and address gaps between psychiatric facilities and homeless service providers.

1C-10f. Protecting Public Safety—Share Information in Accordance with SORNA.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to comprehensively share information, including location information, in accordance with the Sex Offender Registry and Notification Act (SORNA) and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

Pennsylvania's SORNA framework supports comprehensive location information sharing. The May 2025 SMART SORNA Implementation Progress Check found that Pennsylvania met all four minimum SORNA Information Sharing requirements, including collection of identification/ location information and immediate notification of changes to affected jurisdictions and NCIC/NSOR. Pennsylvania law also directs the statewide registry to include residence and, for persons without a fixed residence, temporary habitat information, including a homeless shelter or park.

The Eastern PA CoC's March 2025 Written Standards reinforce information sharing while minimizing unnecessary barriers to housing. The Standards promote low barrier housing access without regard to criminal history and require programs unable to serve a household to work through Coordinated Entry to identify another housing option. Site-based projects may impose restrictions when legally required, including circumstances involving registered individuals who cannot reside near children.

The CoC operates a regional Coordinated Entry system with more than 30 access sites, creating infrastructure for identifying alternative placements when a location restriction applies. The CoC will strengthen this practice by developing a standardized protocol for providers to verify applicable registry/location restrictions, coordinate with appropriate law-enforcement partners when location information must be reported, and immediately route households affected by a restriction through Coordinated Entry for alternative housing. The CoC will monitor registry-related housing denials, alternative referrals, placement outcomes, and time to housing to identify gaps and expand landlord/unit recruitment where restrictions reduce available options. The CoC will also work to train service providers regarding the intersection of SORNA and HMIS information sharing requirements to ensure service providers are well equipped to respond to information requests from law enforcement.

1C-11. Outreach Strategy.

Describe your CoC's strategy to outreach to all individuals and families experiencing homelessness across your geographic area.

(limit 2,500 characters)

The CoC's outreach strategy is to identify, engage & connect every person experiencing homelessness to shelter, treatment & services. Street outreach (SO) is funded through ESG, SSVF, PATH & VA. The frequency of SO varies throughout the CoC from daily SO, to SO efforts that specifically target known locations, to an on-call type of response in the most rural communities. The annual unsheltered PIT count covers 100% of the CoC.

SO teams utilize Language line, including ASL, when needed.

The City of Allentown has multiple SO teams that engage individuals sleeping outside. The community also benefits from street medicine programs working to respond to the medical needs of unsheltered persons. SO teams refer individuals to soup kitchen programs & local service providers to address needs. The community also operates drop-in centers, including one for youth, where unsheltered individuals can engage in services & have basic needs met. Drop-in centers/ day shelters also exist in Monroe & Cumberland counties. In rural areas where people are often out of public view, the CoC relies on a community reporting network of local law enforcement (LE), park rangers, EMS, hospitals, soup kitchens, VFWs, truck stops & all-night laundromats. These partners contact providers when they see someone believed to be unsheltered, & SO or CE staff then go to that location. Hospitals coordinate w/providers before discharging someone who is unsheltered.

PATH outreach in 11 counties targets people w/SMI, including those not yet engaged w/CE. SO staff connect people using substances to their county Single County Authority for assessment & treatment funding, & to DDAP's Warm Handoff pathway from hospital EDs. In counties w/o PATH, SO coordinates w/county MH offices & crisis services.

SSVF/VA outreach workers engage veterans CoC-wide & refer non-veterans to CE.

SO staff complete CE assessments in the field, so no appointment, transportation or office visit is needed. 211 is available CoC-wide via phone & text. SO workers provide tangible aid (food vouchers, sleeping bags, coats, hygiene items, transit passes) to build trust & sustain engagement.

SO teams partner w/MH crisis teams & local LE to provide training, co-response, deescalation, & more.

Street medicine services is a newly eligible Medicaid billable activity, which has increased its availability in some communities & is helping to expand access to CoC resources among highly vulnerable individuals who are unsheltered.

1C-12.	Collaboration Related to Children and Youth–Written Agreements with Early Childhood Services Providers.	
--------	---	--

Select 'Yes' or 'No' in the chart below to indicate whether your CoC or HUD-funded projects in the CoC have written agreements with the listed providers of educational supports and services for children ages 0-5:

		Written Agreement
1.	Child Care (including Child Care and Development Fund)	Yes
2.	Early Childhood Providers	Yes
3.	Early Head Start	Yes
4.	Home Visiting Program (including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	Yes
5.	Head Start	Yes

6.	Healthy Start	No
7.	Public Pre-K	Yes
8.	Tribal Home Visiting Program	No
	Other (limit 150 characters)	
9.		

1C-12a.	Collaboration Related to Children and Youth—Formal Partnerships with Schools and Youth Education Providers.	
---------	---	--

Select 'Yes' or 'No' in the chart below to indicate the youth education providers your CoC has a formal partnership with:

1.	McKinney-Vento Liaison(s) (including State Education Agency (SEA) or Local Education Agency (LEA))	Yes
2.	School District(s)	Yes
3.	General Education Development (GED) Program(s)	Yes
4.	Community College(s)	No
5.	Technical College(s)	No
6.	Other Post-Secondary Education Provider(s)	No

1C-12b. Collaboration Related to Children and Youth—Informing Individuals and Families who Become Homeless about Eligibility for Educational Services.

Describe your CoC's written policies and procedures to inform individuals and families who become homeless of their eligibility for educational services.

(limit 2,500 characters)

The Eastern PA CoC Written Standards, which all CoC/ESG-funded projects must follow as a condition of funding, instructs providers to inform individuals & families who become homeless of their eligibility for educational services. Because Written Standards require case managers to engage households from day one & build a participant-driven housing plan, this happens at the start of services, not only after housing placement. Additionally, CE (through PA 211 & access sites) provide information on eligibility for educational services when relevant.

The Written Standards include general standards for all projects, which includes a section on "Education for Children and Youth Experiencing Homelessness". This section informs all providers that they are required to designate a staff person to be responsible for ensuring children served are enrolled in school, including early childhood education programs, and connected to community services, including Head Start, Part C of IDEA, and McKinney-Vento Education for Children and Youth Experiencing Homelessness (ECYEH) programs. The Written Standards instruct providers to take into account the educational needs of children when families are placed, and to the maximum extent practicable, families w/children should be placed as close as possible to their school of origin so as not to disrupt the children's education. This must also be considered during CE case conferencing of households, prior to making referrals to eligible projects.

When the household is unable to remain in the same school, providers coordinate w/ their regional contact from the McKinney-Vento Education for Children & Youth Experiencing Homelessness (ECYEH) program, who help to ensure the impacted child/ren's core student rights are fulfilled. Additionally, ECYEH staff participate in CoC-wide & regional meetings.

When a household w/children enters a CoC/ESG-funded project, the project's case manager/ designated educational liaison informs the parent or youth of their educational rights as part of intake and case planning. The CoC monitors compliance to this policy through CoC desk monitoring, in which funded agencies affirm a designated educational liaison is in place. The CoC's website provides recorded training on the education rights for children, youth & families for new program staff.

1C-12c. Collaboration Related to Children and Youth—Coordination with Foster Care or Child Welfare Services.

Describe how your CoC coordinates with foster care or child welfare services to assist youth transitioning from public systems of care.

(limit 2,500 characters)

Increased county-level coordination across the CoC's 33 mostly rural counties to prevent homelessness among youth/ young adults w/history of child welfare and/or foster care involvement is a priority.

The Eastern PA CoC & Western PA CoC jointly received HUD Youth Homelessness Systems Improvement (YHSI) funds, led by the CoC's combined YAB & a YHSI Planning Team. YHSI builds formal partnerships among homeless providers, school districts, juvenile justice, foster care & other systems that discharge youth to homelessness at 18 in communities across the CoC. Components of the YHSI project include: (a) Peer-to-Partnership (P2P) Pilot, hiring & training 10 youth w/lived experience for 24 months to work w/county-based youth-serving systems to prevent discharges to homelessness; (b) cross-system data matching w/education, human services & juvenile justice to identify youth at risk before exit; (c) a cross-systems needs & gaps analysis to guide changes in discharge planning. Engaging w/foster care and local Children & Youth Services offices to better support youth & avoid exist to homelessness from foster care is a key component of the YHSI work.

Upon conclusion of the YHSI pilot, the CoC will work to implement recommendations to address the needs of youth.

CoC providers have MOUs in place w/local PHAs for FYI voucher implementation. Multiple PHAs also have FUP vouchers to support aging out youth.

Unaccompanied & emancipated youth under 18 may enroll in CE as heads of household through 211 or an access site, incl. youth-specific access sites, & youth leaving a foster or group home after 90 days or less who were homeless before entry keep literal homeless status. CE Policies call for alignment w/child welfare, & a child temporarily in foster care is counted in family composition so families can reunify in housing.

1C-12d. Collaboration Related to Children and Youth—Coordination with Runaway and Homeless Youth (RHY)-funded Providers.

Describe how your CoC coordinates with RHY-funded providers including Street Outreach Programs, Basic Center Programs, Transitional Living Programs, and Maternity Group Homes where such providers exist.

(limit 2,500 characters)

RHY-funded providers in the CoC include: Valley Youth House; Centre County Youth Service Bureau; and Family Services, Inc. The CoC coordinates w/these providers as follows:

1-Coordinated Entry: Valley Youth House is a Connect to Home CE access site funded through the CoC's Housing Problem Solving grant, so youth can be assessed, placed on the By Name List & referred to shelter/housing where they already receive services. Unaccompanied & emancipated youth under 18 may enroll in CE as heads of household & receive referrals.

2-Street Outreach: Valley Youth conducts youth-specific outreach in the Lehigh Valley, providing assistance with basic needs and connects youth to CE, shelter & housing. Lehigh Valley youth outreach teams regularly conduct a youth-focused PIT within their immediate service catchment.

3-PIT count & data: RHY & youth-serving organizations participate in the CoC-wide annual PIT count and have provided CoC training for youth engagement on multiple occasions.

4- Valley Youth House partners w/Allentown Housing Authority on Foster Youth to Independence vouchers for youth 18-24 leaving foster care, linking TLP & aftercare youth to permanent housing.

5-System planning: these three RHY providers participate on the YHSI Core Team, have helped to inform & support the CoC's Youth Action Board, connect program participants to the YAB for membership, and serve on CoC Committees (e.g. Valley Youth House is a member of the CoC's Coordinated Entry Committee).

1C-13. Collaboration Related to Families with Children—TH or RRH Project Dedicated to Serving Families with Children.

Identify at least one Rapid Rehousing (RRH) or Transitional Housing (TH) project in the CoC that primarily or exclusively serves families with children experiencing homelessness in accordance with 24 CFR 578.93(b).

(limit 500 characters)

While families are included in most of the CoC's TH and RRH projects, only one project is dedicated to families with children – Valley Youth House's RRH for Families. The project is transitioning to a TH program model and is included on the CoC's Priority Listing as PA0808 – Lehigh Valley TH for Families.

1C-13a. Collaboration Related to Families with Children—Supportive Services to Improve Income to Pay Rent.

Describe how the project(s) identified in 1C-13 provides supportive services focused on improving incomes to pay rent, such as workforce development, job training, or registered apprenticeship programs.

(limit 2,500 characters)

Valley Youth House supports families with children to obtain and increase income by focusing case management efforts on employment and job training. While employment and earned income are the goals, the program places an emphasis on clients completing job training while they are in the program in order to increase their future income opportunities and ability to generate sufficient income to pay rent.

Success stories from the last few months include: Two clients became registered Licensed Practical Nurses, one client became a registered Phlebotomist, and another client is completing training to become an EMT. Structure of services: Every participant is paired with a Case Manager to create an Individual Housing Plan. Participants engage in tailored supportive services (case management, counseling, work therapy, education, job training, and community building are documented in a supportive service plan). The Individual Housing Plan includes goals, strategies for achieving goals and target dates to improve health, wellness, housing stability and increased employment income to lead to financial stability and self-sufficiency.

Services are trauma-informed and rooted in Positive Youth Development (PYD). Case managers meet participants weekly for instruction in budgeting, tenancy, life skills. Supportive Service Plans are reviewed annually. VYH directly delivers employment readiness and education support, connecting youth to GED preparation, vocational training, and post-secondary financial aid as well as assisting in securing vital records, building social networks, and accessing legal aid.

To complement direct services, VYH leverages employment & benefits assistance from PA CareerLink for job placement.

Historically, over 80% of participants exit to permanent housing, 75% complete/maintain educational progress (high school/GED/vocational), and 60% achieve employment.

The services offered to Valley Youth House participants, through in-house programming and external community partners, collectively support families to achieve housing stability and economic self-sufficiency.

1C-13b. Collaboration Related to Families with Children—Leveraging Funding from Mainstream Family Service Systems.

Describe how the project(s) identified in 1C-13 leverages funding from mainstream family service systems, such as Temporary Assistance for Needy Families (TANF).

(limit 2,500 characters)

Valley Youth House supports families with children to obtain and increase income & benefits through mainstream services. The project ensures program participants will be individually assisted to obtain the benefits of mainstream health, social, and employment programs for which they are eligible to apply meets the needs of program participants. Staff use the state's online COMPASS portal to determine eligibility and apply for (or renew) all mainstream benefits for which the client may qualify (SSI/SSDI, food stamps, WIC, Medicaid, Medicare, local workforce office, early childhood education, etc.). In addition, referral to SOAR providers are made to expedite SSI/SSDI approvals. Families are offered referrals for and assisted with qualification for subsidized childcare to ensure availability for employment. Parents are also connected to Parents as Teachers, a nationally recognized, free, evidenced-based early childhood service that assists families who are pregnant or have children ages five and under to promote positive parenting, enhance child health and development, prevent child abuse to prepare children for Kindergarten.

1C-13c. Collaboration Related to Families with Children—Combining Housing Assistance with Parental Support.

Describe how the project(s) identified in 1C-13 combines housing assistance with childcare, parenting support, pregnancy-related and child healthcare, and education.

(limit 2,500 characters)

Valley Youth House provides families with referrals & application assistance for subsidized childcare to ensure availability for employment. This includes identifying childcare options that match hours needed to support employment. Parents are also connected to Parents as Teachers, a nationally recognized, free, evidenced-based early childhood service that assists families who are pregnant or have children ages five and under to promote positive parenting, enhance child health and development, prevent child abuse to prepare children for Kindergarten.

Valley Youth House connects clients to healthcare resources in their area to support parenting and pregnant households along with connecting children to a pediatrician. The organization has maintained a partnership with DeSales University nursing students over the past few years and the students are valuable in providing health related information to clients.

Additionally, partnerships for healthcare and Behavioral Health: LVHN Street Medicine Team, Family Health Center, KidsPeace, CONCERN, Dental Dreams, MARS, and CHC provide mobile care, outpatient mental health, primary care, and addiction treatment to enhance wellness and housing retention.

1C-14. Collaboration with Veteran Serving Organizations—Partnership with the U.S. Department of Veterans Affairs or Veteran Serving Organization.

Identify at least one partnership the CoC has with the Department of Veterans Affairs or other Veteran Serving Organizations.

(limit 500 characters)

PA DCED (the CoC's Coll App), in partnership w/PA Dep of Military & Veterans Affairs, co-chair the Gov's Advisory Council on Veterans Services (GAC-VS). This Committee works to improve housing stability, resources, & outreach to veterans across the Commonwealth, including leading the strategy for veterans homelessness response in for the CoC. Additionally, the CoC facilitates CE case conferencing meetings w/veteran services providers to connect veterans to shelter & housing assistance.

1C-14a	Collaboration with Veteran Serving Organizations.	
	Select 'Yes' or 'No' in the chart below to indicate whether the partnership(s) identified in 1C-14 does the following:	

1.	Refers veterans identified by the CoC to VA or other Veteran Serving Organizations for assistance?	Yes
2.	Coordinates the provision of emergency shelter, supportive services, and housing for veterans?	Yes
3.	Ensures access to a full spectrum of employment and career pathway opportunities?	Yes
4.	Shares data with the Department of Veterans Affairs as appropriate?	Yes
5.	Identifies service gaps for veterans?	Yes
6.	Fills service gaps for veterans?	Yes

1C-15. Collaboration with Organizations who Address the Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.

Identify at least one partnership your CoC has with victim service providers, state domestic violence coalitions, state sexual assault coalitions, anti-trafficking service providers or other organizations who help provide shelter, housing, and services to individuals and families of persons experiencing trauma or a lack of safety related to fleeing or attempting to flee domestic violence, dating violence, sexual assault, and stalking.

(limit 500 characters)

Since 2018, the Eastern PA CoC has partnered with the PA Coalition Against Domestic Violence (PCADV), beginning w/ FY18 DV Bonus projects. PCADV helps shape CoC policy & written standards; supports a confidential CE process & the CoC's Emergency Transfer Plan; and trains providers on DV dynamics & trauma-informed care. Its member programs operate survivor-driven shelter, TH, RRH, & PSH projects that serve survivors across the CoC. PCADV also participates in the CoC's CES & DV Committees.

1C-16. Collaboration with Justice System Re-entry Partners.

Identify at least one partnership your CoC has to prevent homelessness among people transitioning from prisons, jails, or court-ordered programs.

(limit 500 characters)

A rep from the PA Dept of Corrections' Office of Reentry Services holds a seat on CoC's Gov Board.

Local Partnership: In Bradford County, housing providers join a monthly interagency meeting at the county jail w/MH court liaison to ID people w/SMI nearing release to plan housing before discharge. A standing law-enforcement consent lets housing staff engage returning clients. People leaving jail after 90 days or less who were homeless at entry are assessed thru CE up to 14 days before release.

1C-17. Collaboration with Partners to Address High Utilizers of Healthcare Systems.

Identify at least one partnership or project your CoC has to provide specialized supportive services for homeless individuals with a high level of medical needs.

(limit 500 characters)

The Lehigh Conference of Churches operates CoC-funded PSH, RRH, and SO projects and provides specialized supportive services for homeless individuals with a high level of medical needs.

1C-18. Collaboration with Partners to Address the Needs of Aging and Elderly Individuals Experiencing Homelessness.

Identify at least one partnership or project your CoC has to serve aging and elderly individuals experiencing homelessness, such as with a provider of residential care, assisted living, or medical respite services.

(limit 500 characters)

The PA Dept of Aging partners w/ P4A & county aging to operate SHARE, a shared housing match-up program, operating in 9 counties across the CoC. SHARE commonly brings together someone experiencing housing instability with an older adult homeowner, who needs asst w/ household chores and/or addntl income to maintain home/taxes/etc. SHARE provides rental asst. if roommate does not have income. This program is stabilizing both participants utilizing existing housing stock.

1C-19. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Project that Prioritizes Individuals Experiencing Chronic Homelessness.

Identify at least one Rapid Rehousing (RRH) or Permanent Supportive Housing (PSH) project that prioritizes individuals experiencing chronic homelessness.

(limit 500 characters)

100% of CoC-funded PSH projects prioritize individuals experiencing chronic homelessness. The Lehigh Conference of Churches is the largest PSH provider within the Eastern PA CoC. They are submitting a PSH renewal – PA-0222 Pathways Permanent Supportive Housing Consolidation and a new project application for 40 new units of PSH.

1C-19a. Permanent Supportive Housing for Chronically Homeless Individuals and Families—On-site Behavioral Healthcare.

Describe how the project(s) identified in 1C-19 provides on-site behavioral healthcare.

(limit 2,500 characters)

The Lehigh Conference of Churches provides a suite of on-site behavioral healthcare services to clients enrolled in their PSH & RRH projects. In partnership with Magellan (BH-MCO), the Lehigh Conference of Churches employs Community Based Care Managers (CBCMs) for “high utilizers” of services in Lehigh & Northampton Counties. The goal of the program is to keep these highly vulnerable individuals out of a health care setting (e.g. hospital) & to support their ability to remain stably housed in the community. CBCMs receive a daily list of people who are in local hospitals who qualify for this program. In addition to intensive case management through the CBCMs, direct client assistance is available through the Social Determinants of Health (SDOH) program. CBCMs connect participants to SNAP, medical benefits, SOAR, & all mainstream benefits. SDOH provides: transportation to medical appointments; food that is appropriate based on dietary needs but not covered by SNAP; supports client move in to a new home; provides education & job training, as well as the cost of licenses/certifications (e.g. CNA, CDL); child care; and more. Housing assistance is provided by Lehigh & Northampton counties through their Housing Clearinghouse. In addition to the above project, the Lehigh Conference of Churches utilizes Medicaid-reimbursable Intensive Case Managers (ICMs) to support eligible individuals in their RRH & PSH projects. These ICMs assist program participants, in addition to their housing case manager, to obtain/ maintain stable housing and address medical and behavioral health care needs. This includes assisting with the development and implementation of client goal plans, medication compliance, and connections to address all behavioral healthcare needs. Additionally, Certified Peer Specialists (CPS) and Certified Recovery Specialists (CRS) are available to support PSH clients. CPS/CRS walk alongside clients to support their housing stability and overall recovery. The Conference of Churches operates a daily drop-in center where PSH clients can come to obtain services, resources, have appointments, and engage in groups/classes. Doctors operate a clinic at the drop-in center at least once per month and are on-site to provide medical care.

1C-19b. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Assesses Need for Higher Level of Care.

Describe how the project(s) identified in 1C-19 has a policy for assessing program participant need for higher level of care (i.e., assisted living, residential treatment).

(limit 2,500 characters)

The Lehigh Conference of Churches has a clinical case manager on staff who monitors PSH clients who have higher level of care needs. Project policies outline that when a PSH participant is showing signs of decompensation, of unaddressed medical needs, etc. the housing case manager alerts the clinical case manager, who begins to monitor that individual. Through staff on boarding, all housing case managers are taught to recognize warning signs of declining health. This includes: the client not physically caring for themselves (e.g. not showering); significant weight loss; changes in mobility; not leaving housing unit; missing doctor's appointments; not taking medication; unexplained changes in behavior; behaviors that result in concerns for physical safety; etc. At this point, the clinical case manager will assess the PSH participant to determine if a higher level of care is needed. If so, additional supports are coordinated to address the level of care needs. When a PSH participant needs assisted living, nursing home, or other institutional care, the clinical case manager will help to find an open bed in a location that insurance will cover.

1C-19c. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Assesses Readiness for Moving On.

Describe how the project(s) identified in 1C-19 has a policy for assessing program participant readiness for moving on to unsubsidized or other permanent housing.

(limit 2,500 characters)

The CoC has developed training and materials to support Moving On initiative. In the Lehigh Conference of Churches PSH project, once clients are stabilized and healthy and able to live independently without PSH-level supports, other permanent housing options are identified and applications are submitted. Most commonly, PSH participants move on to housing programs operated by the area's Public Housing Authorities, LIHTC projects, or other senior housing programs. Additionally, PSH participants move on because they have adequate income from SSDI, or SSI combined with employment to support rent without assistance. In some cases, PSH participants move on as a result of family reunification. Once they have become sober, healthy, have worked through behavioral health and addiction issues, and have income (e.g. SSI) they re-establish relationships with family members. After time, this sometimes creates a pathway for them to return home with their family. If they want to maintain their unit and have family move into their home. Lehigh Conference of Churches will work with the landlord to transfer the lease to the client. Lehigh Conference of Churches also operates RRH. In RRH, when they move someone into the unit they estimate their earning potential and housing locators help the program participant to find a unit within their budget. Once the participant gains employment, they are then able to take over their own rental payments and successfully exit the project.

1D. Project Capacity, Review, and Ranking–Local Competition

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- Frequently Asked Questions

1D-1.	Project Review and Ranking Process Your CoC Used in Its Local Competition. We use the response to this question along with the required attachment as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.	
-------	---	--

You must upload the Local Competition Scoring Tool attachment to the 4A. Attachments Screen.

Select 'Yes' or 'No' in the chart below to indicate how your CoC reviewed, rated, and ranked project applications during your local competition:

1.	Established total points available for each project application type.	Yes
2.	At least 50 percent of the total available points were based on objective criteria to review, rate, and rank project applications.	Yes
3.	At least 25 percent of the total available points were based on system performance measures to review, select and rate project applications.	Yes
4.	Considered returns to homelessness in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes
5.	Considered employment income in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes
6.	Considered supportive service participation requirements in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes

1D-2.	New Proposals.	
	Does your CoC invite new proposals from entities that have not previously received funding, if such eligible entities exist?	Yes

1D-2a.	Web Posting of CoC-Approved Consolidated Application Before the CoC Program Competition Application Submission Deadline.	
--------	--	--

	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website—which included: 1. the CoC Application, and 2. Project Priority Listings.	09/30/2026
--	---	------------

1D-2b.	Notification to Community Members and Key Stakeholders by Email that the CoC-Approved Consolidated Application is Posted on the Website.	
--------	--	--

	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/30/2026
--	---	------------

1D-2c.	Local Competition Selection Results for All Projects.	
	You must upload the Local Competition Selection Results attachment to the 4A. Attachments Screen.	

	Does your attachment include: 1. Project Names, 2. Project Scores, 3. Project Rank, 4. Project Status—Accepted, Rejected, Reduced Reallocated, Fully Reallocated, 5. Amount Requested from HUD, and 6. Reallocated Funds +/-.	Yes
--	---	-----

1D-2d.	Projects Rejected/Reduced—Notification Outside of e-snaps.	
--------	--	--

1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	09/14/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

1D-2e.	Projects Accepted—Notification Outside of e-snaps.	
--------	--	--

	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	09/23/2026
--	---	------------

1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
-------	--	--

	Describe:
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

1)CoC's reallocation process is outlined in CoC Funding Policies, updated annually & approved by the Board. The document is circulated to CoC-funded providers & publicly posted on the CoC website at the start of the renewal scoring process annually (April 2026). CoC identifies projects that were low performing, underspending, or had cost effectiveness concerns via annual project evaluation/scoring process. The annual eval looks at factors such as data quality; participant outcomes for income, PH exits, returns; grant management, including spenddown; & CoC participation. CoC's gaps analysis is also used to ID where funding is needed.

CoC may consider reallocation based on: underperformance; underspending; lack of need; or monitoring indicates serious problems. Projects are considered for involuntary reallocation if they have underperformance or underspending for 2+ years. First, however, the CoC provides an official letter outlining the concerns, offers TA, & requests grantee to provide a written response outlining plan to resolve. If performance does not improve after receiving this official notice, CoC may consider the project for reallocation. Recommendation decisions, for full or partial reallocation, are determined & overseen by the CoC's Funding Committee.

Agencies w/ projects subject to reallocation are provided w/opportunity to submit an appeal, as indicated in CoC's Funding Policies. If a project receives a warning, but not reallocated, reasons include: project is making progress to address issues; project performance has increased more recently; the issues are more administrative vs. service delivery focused, which is a significant consideration in our most rural communities that oftentimes only have one provider/project.

2+3) Following this year's renewal scoring process & the release of the 2026 CoC NOFO, the CoC identified & reallocated projects deemed to be of a lesser priority/need in response to HUD's priorities, including several RRH projects. In addition, 2 PSH projects (VHDC, LCHA) were reallocated due to underperformance & underutilization across multiple funding years. RHD's PSH project was partially reallocated due to underspending & underutilization.

4) The CoC reallocated many low performing or lesser needed projects. There were not enough high-quality applications for additional reallocations to be needed. The CoC will follow up w/remaining low performing projects to address concerns thru process outlined above.

1D-3a.	Reallocation Between FY 2021 and FY 2026.	
--------	---	--

	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2021 and FY 2026?	Yes
--	--	-----

2A. Homeless Management Information System (HMIS) and System Performance

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

2A-1.	HMIS Vendor.	
	Not Scored—For Information Only	

	Enter the name of the HMIS Vendor your CoC is currently using.(limit 75 characters)	ClientTrack by CaseWorthy
--	---	---------------------------

2A-2.	HMIS Implementation Coverage Area.	
	Not Scored—For Information Only	

	Select from dropdown menu your CoC's HMIS coverage area.	Multiple CoCs
--	--	---------------

2A-3.	PIT Count—Methodology Change.	
-------	-------------------------------	--

	Describe:
1.	any changes your CoC made to your unsheltered PIT count implementation, including methodology or data quality changes between 2025 and 2026, if applicable, and
2.	how the changes affected your CoC's PIT count results.

(limit 2,500 characters)

Not Applicable

2A-4. Reduce Encampments—Actions to Reduce Encampments.

Describe in the field below the actions your CoC took to reduce the number of encampments or the number of people residing in encampments during your evaluation period.

(limit 2,500 characters)

CoC used 01/24-01/25 as evaluation period. The 2025 PIT Count identified 478 unsheltered people in 369 households, comprising 28% of the 166 total people counted. The number of unsheltered individuals decreased by 14 individuals between the 2024 and 2025 PIT Counts (2.8%), which occurred in the last 10 days of January for each respective year. Data is collected for each county, including a survey to identify which counties included encampments and an opportunity to describe the location of individuals counted. In both 2024 and 2025, 12 counties within the CoC identified counting at least one encampment. Within these 12 counties, there was a reduction in the number of people experiencing unsheltered homelessness from 401 in 2024 to 365 in 2025 – a 36-person reduction and 8.9% decrease. Location data was not available or lacked detail for many of the unsheltered individuals counted in 2024 and 2025, thus total unsheltered homelessness was entered for 2A-4a, despite the possibility that many individuals counted may not have been in a setting that would commonly be described as an encampment. In more rural communities, unsheltered individuals often reside independently compared to urban areas where many may congregate in one location. Between 01/24 and 01/25, multiple municipalities launched or expanded efforts to address encampments. For example, in 2024, the city of Bethlehem began implementing their formal Strategic Plan to Address Homelessness, with a focus on responding to safety and sanitation concerns in public places. The city worked to address findings included in their strategic plan that local responses to homelessness were more reactive than proactive by working to prioritize long-term holistic approaches, including strategizing to improve shelter options to ensure reasonable alternatives could be provided for individuals living in encampments facing closures. In Allentown, a special City Council committee began researching co-response public safety models and promoting collaboration between Community Intervention Specialist and city police. These two communities have the largest prevalence of encampments within the CoC and initiatives piloted in these regions reinforced CoC-wide conversations regarding enforcement strategies, co-response opportunities, increasing shelter capacity, and effective interventions for encampment settings.

2A-4a.	Reduce Encampments—Number of Encampments.	
--------	---	--

1. Enter the estimated number of encampments in the beginning of your evaluation period.	401
2. Enter the reduction in the number of encampments during your evaluation period.	36

2A-4b.	Reduce Encampments—Number of People in Encampments.	
--------	---	--

1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	401
2. Enter the reduction in the number of people in encampments during your evaluation period.	36

2A-4c.	Reduce Encampments—Plans to Reduce Encampments.
--------	---

If there has been no reduction in encampments or persons in encampments in your CoC, describe the plans your CoC has to participate in efforts to reduce these numbers.

(limit 2,500 characters)

12 counties within the CoC identified counting at least one encampment. Within these 12 counties, there was a 36-person reduction and 8.9% decrease. Data provided in 2A-4 and 2A-4b indicate 401 unsheltered individuals in 2024 to 365 in 2025. During 2024 and 2025 the CoC did not track precise quantities of encampments across the CoC. The CoC plans to further encampment data collection via PIT Count surveys to ensure consistent measurement of both the number of encampments and the number of people residing in encampments. The CoC will engage each Regional Homeless Advisory Board to identify encampments within each region and develop targeted strategies. The CoC has contracted with the Housing Alliance of PA to assess the success of existing encampment response initiatives (e.g. Bethlehem, Allentown), including stakeholder engagement with law enforcement, city officials, co-response teams, and homeless service providers to identify opportunities for continuous quality improvement. Deliverables for this contract include standards, policies, and toolkits that can be adapted depending on the needs of each city/county.

2A-5. Reducing the Number of First Time Homeless—CoC's Plan.

Describe your CoC's plan to decrease the number of individuals and families becoming homeless for the first time.

(limit 2,500 characters)

Across all 33 counties, the CoC identifies risk factors for first-time homelessness by analyzing Coordinated Entry (CE) prevention screening data, HMIS & results of its yearlong diversion pilot. Key risk factors include institutional discharge w/no home plan, loss of employment, families w/young children & DV. The CoC's annual gaps analysis uses CE data to show who is entering the system, their service needs & service gaps at the CoC, regional & county levels, so communities can see where households are waiting for assistance, how long they are waiting, and how many households did not receive assistance. These findings are shared with the CoC & utilized by the Funding Committee to inform new project selection.

CE (211 & 30+ access sites) screens every household for risk & connects those at imminent risk (Category 2) directly to homelessness prevention, incl. ESG prevention, the county Homeless Assistance Program (HAP) & SSVF for veterans (within 30 days of housing loss). Eligible households may be referred to ESG prevention in another CoC county when none is open locally.

Building on lessons from ERAP/ESG-CV prevention & a diversion pilot project, the Governing Board approved a CoC-wide Housing Problem Solving (HPS) strategy (prevention, diversion & rapid exit), funded by Home4Good (PHFA/FHLB-Pittsburgh). CE Specialists attempt an HPS conversation during CE intake to help households identify safe options w/family, friends or other supports, w/flexible financial assistance when needed; 12 HPS-funded access sites are required to record every attempt in HMIS so outcomes can be tracked. CoC RRH funds may also be used for Rapid Exit (one-time assistance to exit system).

To reduce homelessness among households fleeing DV, the CoC is working w/PCADV to retool its DV CE project, which will be more responsive to preventing the loss of housing & rapid exit.

CoC providers in some communities coordinate w/prisons/jails, health care, residential care & foster care so people are not discharged to homelessness, incl. the YHSI initiative to prevent youth exiting public systems from becoming homeless.

The data on older adults experiencing homelessness has also been increasing. The CoC will work to better understand these increases and work to develop partnerships & strategies w/Area Agencies on Aging, senior housing & other relevant partners to begin to reverse this trend.

2A-6. Reducing Length of Time Homeless—CoC's Plan.

Describe your CoC's plan to reduce the length of time individuals and families remain homeless.

(limit 2,500 characters)

The CoC implements many strategies to reduce the length of time Homeless (LOTH) for households:

- Shelter engagement – new projects are included on the 2026 priority list that will support earlier engagement of individuals in shelter, reduce referral times, & enhance support around rapid exit among employed households.
- Written Standards prioritize vulnerability & length of time homeless for all PH.
- Increased access to a full continuum of housing: The CoC is prioritizing new treatment-focused TH, recovery housing & SSO in the FY2026 competition so people are not waiting in shelter or outdoors for one housing type.
- All projects use Service Participation Agreements with Individualized Service & Housing Stability Plans.
- Landlord engagement – the CoC was awarded state PHARE funding (PA HTF) to facilitate CoC-wide landlord incentive program to offset the potential risk taken by the landlord. This will allow providers to more easily identify units for households (HHs).
- Housing Problem Solving (HPS) – to prevent/ divert/ rehouse HHs as quickly as possible after CE contact. CoC funding HPS through Home4Good (PHFA & FHLB-Pitts funding). CoC also piloting rapid exit, to minimize # days in shelter/ unsheltered for HHs that have income.
- CE Strategies – The CoC submitted on its new project priority listing a new CE project that will add significant capacity to the system. This will include system navigators to connect individuals to employment support resources & BH/SUD resources more quickly. In addition, this project will fund staff to provide document readiness support for a more expedient move in once referrals are made to housing providers. CoC CE assessment includes questions about LOT homeless, which impacts how HHs are prioritized for assistance, per the CoC's written standards. The CE By Name List includes LOTH as a visible field, which is used for referral prioritization along w/chronicity. Street outreach teams conduct CE assessments to reduce time until a resource can be identified.

2A-7.	Successful Permanent Housing Placement—Exits to Unsubsidized Housing.	
	Based on HMIS data, what percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing?	64.93%

Describe how you calculated the data for this response.

(limit 2,500 characters)

The percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing was calculated as follows:

- A System Performance Measures Metric 7 report for 10/1/23 to 9/30/24 (FFY24) was run in the CoC's HMIS. Projects selected for the report were limited to PSH, RRH, and TH projects, including CoC- and non-CoC funded projects (such as ESG, VASH, SSVF, etc.).
- The report included all participants who exited from PSH, RRH, and TH projects operating in the CoC during FFY24 with the exit destination for each participant included. The report separated RRH and TH participants into a Metric 7b1 sub-report and PSH participants into a 7b2 sub-report.
- The data was exported into an Excel workbook, with 7b1 and 7b2 data on separate worksheets.
- The participant data from Metrics 7b1 and 7b2 were combined into a single excel worksheet.
- A pivot table was run on the Excel worksheet with the combined data to determine the total number of participants who exited from the CoC's PSH, RRH, and TH projects during FFY24. The total number of exits was 1993.
- A second pivot table was run, filtering the data to count only the exits from PSH, RRH, and TH projects to the four categories of exits to unsubsidized permanent housing destinations: Staying or living with family, permanent tenure; Staying or living with friends, permanent tenure; Rental by client, no ongoing housing subsidy; and Owned by client, no ongoing housing subsidy. The total number of exits to those destinations was 1294.
- The outcome was calculated as follows: 1294 exits to unsubsidized housing destinations from PSH, RRH, and TH projects / 1993 total exits from PSH, RRH, and TH projects = 64.93% of participants exits from PSH, RRH, and TH projects were to unsubsidized permanent housing destinations during FFY24.
- If the universe was limited to CoC-funded projects only, the outcome would be: 655 exits to unsubsidized housing destinations from CoC-funded PSH, RRH, and TH projects / 926 total exits from CoC-funded PSH, RRH, and TH projects = 70.73% of participants exits from CoC-funded PSH, RRH, and TH projects were to unsubsidized permanent housing destinations.

2A-8.	Housing Inventory Count (HIC) and Point-in-Time (PIT) Count Date.	
-------	---	--

	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/21/2026
--	---	------------

2A-8a.	HIC and PIT Count Data—HDX 2.0 Submission Date.	
--------	---	--

	Did your CoC submit its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count data in HDX 2.0 by April 30, 2026, 8:00 p.m. EDT?	Yes
--	--	-----

2A-8b.	Longitudinal System Analysis (LSA) Data—HDX 2.0 Submission Date.	
	You must upload your CoC's FY 2026 HDX Competition Report to the 4A. Attachments Screen.	

Did your CoC submit at least two usable LSA data files to HUD in HDX 2.0 by January 16, 2026, 11:59 p.m. EST?	Yes
---	-----

2A-8c.	System Performance Measures (SPM) Data—HDX 2.0 Submission Date.	
--------	---	--

Did your CoC submit its FY 2025 System Performance Measures data in HDX 2.0 by March 4, 2026, 8:00 p.m. EDT?	Yes
--	-----

2A-9.	HMIS and Comparable Database Participation—Bed Coverage Rate.	
-------	---	--

Using the FY 2026 HDX Competition Report we issued your CoC, enter data in the chart below by project type:

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	1,121	247	1,147	83.85%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	584	28	378	61.76%
4. Rapid Re-Housing (RRH) beds	938	441	1,364	98.91%
5. Permanent Supportive Housing (PSH) beds	977	38	658	64.83%
6. Other Permanent Housing (OPH) beds	143	0	66	46.15%

2A-9a.	Partial Credit for Bed Coverage Rates of 84.99 Percent or Lower for Any Project Type in Question 2A-9.	
--------	--	--

For each project type with a bed coverage rate that is 84.99 percent or lower in question 2A-9, describe:

1.	steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type, and
2.	how your CoC will implement the steps described to increase bed coverage to at least 85 percent.

(limit 2,500 characters)

1) Most non-participating providers are faith & community based (ES, TH), w/some Veteran service EHA providers (ES), other providers funded by related state agencies not required to participate in HMIS (ES), VASH PSH vouchers & some PHAs (OPH). To increase HMIS coverage for ES, TH, PSH & OPH, the CoC will:

- Provide bonus points w/in renewal scoring criteria to CoC-funded orgs that enter HMIS data for its non-ESG/CoC-funded projects;
- Continue to pay for HMIS user licenses to all organizations operating homeless assistance programs;
- Explore expanded use of APIs that allow the HMIS to upload/transfer/ share data w/non-HMIS data collection systems. This is a popular feature w/Community Action Agencies, as it reduces the need for staff to enter data into multiple systems. A local rescue mission has also expressed interest in sharing data through an API.
- Engage w/Veterans service providers to ensure that all Veterans are included directly into HMIS as well as their other required systems.
- Work to expand HMIS data entry among VASH vouchers, which account for 343 (of 357) PSH beds not participating in HMIS (96%)
- Conduct focus groups w/orgs that participate in CoC but not in HMIS to better understand the barriers to use. CoC will establish a workplan to address barriers & market HMIS reporting & dashboard tools.
- Continue coordination & planning between CE and HMIS staff through joint meetings, to identify needed enhancements.
- Coordinate to require use of HMIS for projects funded by other state agencies that serve homeless constituents. For ex, the CoC will work to leverage the tracking of housing activities funded through the State's recently approved 1115 Waiver, along with local Social Determinants of Health resources. This would bring many new users into HMIS, many of whom already operate non-HMIS participating homeless assistance projects.

2) To implement the above:

- HMIS staff will work to implement APIs where possible.
- CoC will request these topics to be agenda items at quarterly HMIS Joint Advisory Committee for discussion and input from the other CoCs that utilize PA-HMIS.
- CoC will add HMIS to the standing agendas for meetings with both HMIS participating and non-participating providers.
- Coordinate with VAMCs around HMIS data entry and/or API to share data.

3A. Policy Initiatives

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- Frequently Asked Questions

3A-1.	Supporting Activities within an Opportunity Zone.	
	You must upload the HUD-2996 Certification for Opportunity Zone Preference Points attachment to the 4A. Attachments Screen.	

1.	Will the proposed activities/projects occur within Opportunity Zone Census Tracts?	Yes
2.	Do you expect to use at least 50% of the proposed activities/projects in Opportunity Zones Census Tracts?	No

3A-2	Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.
------	---

Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes? No

4A. Attachments Screen For All Application Questions

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

We have provided the following guidance to help you successfully upload attachments and get maximum points:

1. You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.
2. You must upload an attachment for each document listed where 'Required?' is 'Yes'.
3. We prefer that you use PDF files, though other file types are supported—please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.
4. Attachments must match the questions they are associated with.
5. Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process.
6. If you cannot read the attachment, it is likely we cannot read it either.
 - . We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).
 - . We must be able to read everything you want us to consider in any attachment.
7. After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.
8. Only use the 'Other' attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.

Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	List of Projects ...	09/30/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	Substance Use Tre...	09/30/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	Supportive Servic...	09/30/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	Evidence of Coord...	09/30/2026
05. 1D-1. Local Competition Scoring Tool	Yes	Local Competition...	09/30/2026

06. 1D-2c. Local Competition Selection Results	Yes	Local Competition...	09/30/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	2026 HDX CoC Comp...	09/30/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No		
09. 3A-2a. Project List for Other Federal Statutes	No		
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No	3A-DP Policy to A...	09/30/2026
11. Other	No		

Attachment Details

Document Description: List of Projects and Treatment Providers with on-site substance use treatment

Attachment Details

Document Description: Substance Use Treatment Required attachment

Attachment Details

Document Description: Supportive Services Agreements

Attachment Details

Document Description: Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety

Attachment Details

Document Description: Local Competition Scoring Tool

Attachment Details

Document Description: Local Competition Selection Results Attachment

Attachment Details

Document Description: 2026 HDX CoC Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: 3A-DP Policy to Advance Recovery

Attachment Details

Document Description:

Submission Summary

Ensure that the Project Priority List is complete prior to submitting.

Page	Last Updated
1A. CoC Identification	09/30/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/30/2026
1C. Coordination and Engagement	09/30/2026
1D. Project Review/Ranking	09/30/2026
2A. HMIS Implementation	09/30/2026
3A. Policy Initiatives	09/30/2026
4A. Attachments Screen	09/30/2026
Submission Summary	No Input Required

FY 2026

PA-509 Eastern Pennsylvania

Continuum of Care

**1C-1. List of TH/RRH/PSH Projects and
Treatment Providers with On-Site Substance
Use Treatment**

Documents include the following:

- **Pages 2-4: Chart showing which PA-509 TH, PH-RRH & PH-PSH projects have on-site substance use treatment available, including the name of the treatment provider**

**PA-509 CoC: 1C-1. List of TH/RRH/PSH Projects and Treatment Providers
with On-Site Substance Use Treatment**

Number of TH, RRH, PSH Projects:	50
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	2
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	4%

Applicant Name	Project Name	Project Type	On-site Substance Use Treatment Available?	Name(s) of Treatment Provider(s)
Bradford County Human Service Agency	Transitional Housing Project 2026	TH	No	
Breaking the Barriers	BTB Transitional Housing	TH	No	
Catholic Social Services of the Diocese of Scranton, Inc.	PA0519-PSHP Pike County	PH-PSH	No	
Catholic Social Services of the Diocese of Scranton, Inc.	PA0386-Rural Permanent Supportive Housing	PH-PSH	No	
Catholic Social Services of the Diocese of Scranton, Inc.	PA0450-Susquehanna/Wayne PSHP	PH-PSH	No	
Center for Community Action	PA1062 Rural Set Aside PSH Hardwoods	PH-PSH	No	
Center for Community Action	PA0661 South Central TH	TH	No	
Center for Community Action	PA1138 Central Valley JMSU TH	TH	No	
Center for Community Action	PA0372 Blair County TH	TH	No	
Centre County Government	PA0814 Centre County Transitional Housing Program	TH	No	
Clinton County Housing Coalition	PA1063 Lincoln Apartments PSH SS Expansion	PH-PSH	No	
Clinton County Housing Coalition, Inc.	Lincoln Apartments	PH-PSH	No	
Clinton County Housing Coalition, Inc.	PA0966 Clinton County Transitional Housing Project	TH	No	
Community CARES	Waypoint Transitional Housing	TH	No	
County of Franklin	PA0649 - Franklin/Fulton S+C Project	PH-PSH	No	
Fitzmaurice Community Services, Inc	PA0214 - Pathfinders PSH	PH-PSH		
Housing Authority of the County of Cumberland	PA0447 - PSH Consolidated	PH-PSH	No	
Housing Authority of the County of Cumberland	PA0812 Transitional Housing	TH	No	
Housing Development Corporation of NEPA	PA0384 HDC SHP 3 2026	PH-PSH	No	
Housing Development Corporation of NEPA	PA0582 HDC SHP 6 2026	PH-PSH	No	
Housing Transitions	PA0176 Nittany Housing Apartments Expansion	PH-PSH	No	
Housing Transitions, Inc.	PA0176 Nittany House Apartments	PH-PSH	No	
Lebanon Rescue Mission	Safe Haven Partnership	TH	No	
Monroe, County of	PA1087 - Pocono Mountains Transitional Housing Project FY2026	TH	No	
New Bethany, Inc.	New Bethany Transitional Housing Project	TH	No	
Northern Cambria Community Development Corporation	PA0360 Independence Gardens	PH-PSH	No	

**PA-509 CoC: 1C-1. List of TH/RRH/PSH Projects and Treatment Providers
with On-Site Substance Use Treatment**

Number of TH, RRH, PSH Projects:	50
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	2
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	4%

Applicant Name	Project Name	Project Type	On-site Substance Use Treatment Available?	Name(s) of Treatment Provider(s)
Pennsylvania Coalition Against Domestic Violence	PA1088 Eastern PA CoC DV RRH Consolidation Renewal FY26	PH-RRH	No	
Pennsylvania Coalition Against Domestic Violence	PA1137 FY26 NEW Eastern PA CoC DV TH	TH	No	
Perry Housing Partnership	PA0177 Perry Veterans SHP	TH	No	
Perry Housing Partnership	Perry County TH Program	TH	No	
Resources for Human Development, Inc.	PA0449-Crossroads Housing Bonus Expansion	PH-PSH	No	
Schyulkill Community Action Agency	Bridge House Transitional Housing	TH	No	
Service Access and Management Inc.	PA1031 Daybreak Transitional Housing	TH	No	
Tableland Services, Inc.	PA0705 Consolidated Permanent Supportive Housing with Disabilities	PH-PSH	Yes	Open Rhodes 2 Recovery
Tableland Services, Inc.	PA0366 Transitional Housing Project	TH	Yes	Open Rhodes 2 Recovery
The Lehigh Conference of Churches	PA0222 - Pathways Permanent Supportive Housing Consolidation	PH-PSH	No	
The Lehigh Conference of Churches	Pathways II Permanent Supportive Housing	PH-PSH	No	
The Lehigh Conference of Churches	PA0222 Pathways Permanent Supportive Housing Consolidation Expansion	PH-PSH	No	
The Lehigh Conference of Churches	PA1029 - Pathways TH	TH	No	
The Salvation Army, a New York Corporation	Allentown Hospitality House Permanent Housing Program	PH-PSH	No	
The Salvation Army, a New York Corporation	Salvation Army Carlisle PH Project	PH-PSH	No	
Third Street Alliance for Women & Children	PA0811 Third Street Alliance Transitional Housing	TH	No	
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing	PH-PSH	No	
Transitions of PA	PA1139 Transitions of PA PSH for Snyder and Northumberland Counties	PH-PSH	No	
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing Expansion	PH-PSH	No	
Transitions of PA	PA0859 SUN Counties Transitional Housing for Survivors	TH	No	
Transitions of PA	Transitions of PA Regional Transitional Housing for Survivors	TH	No	
Valley Youth House Committee, Inc.	PA0887 - Lehigh Valley TH for Youth	TH	No	

**PA-509 CoC: 1C-1. List of TH/RRH/PSH Projects and Treatment Providers
with On-Site Substance Use Treatment**

Number of TH, RRH, PSH Projects:	50
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	2
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	4%

Applicant Name	Project Name	Project Type	On-site Substance Use Treatment Available?	Name(s) of Treatment Provider(s)
Valley Youth House Committee, Inc.	PA0808 - Lehigh Valley TH for families	TH	No	
Women's Help Center	The Way Home Transitional Housing Project	TH	No	

FY 2026

PA-509 – Eastern Pennsylvania

Continuum of Care

**1C-1f. List of CoC Program Projects and
Number of Units that Require Substance
Abuse Treatment**

Documents include the following:

- **Pages 2-4: Chart showing which PA-509 TH, PH-RRH & PH-PSH project units require substance use treatment, including the number of units**

PA-509 CoC: 1C-1f. List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment

Persons reporting chronic substance use in the CoC's 2026 PIT count:	106
Number of Units w/Required Substance Use Treatment:	29
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	1 : 3.7

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
Beahive Affordable Housing Outreach, Inc.	Hive Stability Program	SSO-Standalone	N/A
Bradford County Human Service Agency	Transitional Housing Project 2026	TH	0
Breaking the Barriers	BTB Transitional Housing	TH	0
Catholic Social Services of the Diocese of Scranton, Inc.	PA0519-PSHP Pike County	PH-PSH	0
Catholic Social Services of the Diocese of Scranton, Inc.	PA0386-Rural Permanent Supportive Housing	PH-PSH	0
Catholic Social Services of the Diocese of Scranton, Inc.	PA0450-Susquehanna/Wayne PSHP	PH-PSH	0
Center for Community Action	PA1062 Rural Set Aside PSH Hardwoods	PH-PSH	0
Center for Community Action	PA0661 South Central TH	TH	0
Center for Community Action	PA1138 Central Valley JMSU TH	TH	0
Center for Community Action	PA0372 Blair County TH	TH	0
Center for Community Action	Eastern PA CoC Coordinated Entry	SSO - CE	N/A
Centre County Government	PA0814 Centre County Transitional Housing Program	TH	0
Clinton County Housing Coalition	PA1063 Lincoln Apartments PSH SS Expansion	PH-PSH	0
Clinton County Housing Coalition, Inc.	Lincoln Apartments	PH-PSH	0
Clinton County Housing Coalition, Inc.	PA0966 Clinton County Transitional Housing	TH	0
Commonwealth of Pennsylvania	PA0188 Commonwealth of PA HMIS (PA-509) FY2026	HMIS	N/A
Community CARES	Waypoint Transitional Housing	TH	0
Community CARES	Community CARES Housing Connections	SSO - Standalone	N/A
County of Franklin	PA0649 - Franklin/Fulton S+C Project	PH-PSH	0
Fitzmaurice Community Services, Inc	PA0214 - Pathfinders PSH	PH-PSH	0
Housing Authority of the County of Cumberland	PA0447 - PSH Consolidated	PH-PSH	0
Housing Authority of the County of Cumberland	PA0812 Transitional Housing	TH	0
Housing Development Corporation of NEPA	PA0384 HDC SHP 3 2026	PH-PSH	0
Housing Development Corporation of NEPA	PA0582 HDC SHP 6 2026	PH-PSH	0

PA-509 CoC: 1C-1f. List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment

Persons reporting chronic substance use in the CoC's 2026 PIT count:	106
Number of Units w/Required Substance Use Treatment:	29
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	1 : 3.7

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
Housing Transitions	PA0176 Nittany Housing Apartments Expansion	PH-PSH	0
Housing Transitions	Housing Transitions Street Outreach	SSO - Street Outreach	N/A
Housing Transitions, Inc.	PA0176 Nittany House Apartments	PH-PSH	0
Lebanon Rescue Mission	Safe Haven Partnership	DV TH	0
Monroe, County of	PA1087 - Pocono Mountains Transitional Housing Project FY2026	TH	0
New Bethany	New Bethany Southside Drop-in Center Supportive Services Project	SSO - Standalone	N/A
New Bethany, Inc.	New Bethany Transitional Housing Project	TH	0
New Hope Ministries	Pathways to Housing Stability	SSO - Standalone	N/A
Northern Cambria Community Development Corporation	PA0360 Independence Gardens	PH-PSH	0
Pennsylvania Coalition Against Domestic Violence	PA1088 Eastern PA CoC DV RRH Consolidation Renewal FY26	PH-RRH	0
Pennsylvania Coalition Against Domestic Violence	PA1137 FY26 NEW Eastern PA CoC DV TH	TH	0
Pennsylvania Coalition Against Domestic Violence	PA1119 Eastern PA CoC DV CE Extension Renewal FY26	SSO-CE	N/A
Pennsylvania Coalition Against Domestic Violence	PA0927 Coordinated Entry Specialist for Domestic Violence	SSO-CE	N/A
Perry Housing Partnership	PA0177 Perry Veterans SHP	PH-PSH	0
Perry Housing Partnership	Perry County TH Program	TH	0
Resources for Human Development, Inc.	PA0449-Crossroads Housing Bonus Expansion	PH-PSH	0
Schuykill Community Action Agency	Bridge House Transitional Housing	TH	18
Servants to All	SSO-Street Outreach	SSO - Street Outreach	N/A
Service Access and Management Inc.	PA1031 Daybreak Transitional Housing	TH	0
Tableland Services, Inc.	PA0705 Consolidated Permanent Supportive Housing with Disabilities	PH-PSH	0
Tableland Services, Inc.	PA0366Transitional Housing Project	TH	0
The Lehigh Conference of Churches	PA0222 - Pathways Permanent Supportive Housing Consolidation	PH-PSH	0
The Lehigh Conference of Churches	Pathways II Permanent Supportive Housing	PH-PSH	0

PA-509 CoC: 1C-1f. List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment

Persons reporting chronic substance use in the CoC's 2026 PIT count:	106
Number of Units w/Required Substance Use Treatment:	29
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	1 : 3.7

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
The Lehigh Conference of Churches	PA0222 Pathways Permanent Supportive Housing Consolidation Expansion	PH-PSH	0
The Lehigh Conference of Churches	PA1029 - Pathways TH	TH	0
The Lehigh Conference of Churches	PA0213 - Outreach and Case Management for the Disabled, Chronically Homeless	SSO	N/A
The Lehigh Conference of Churches	Street Outreach	SSO - Street Outreach	N/A
The Lehigh Conference of Churches	Daybreak Drop-In Center	SSO - Standalone	N/A
The Salvation Army, a New York Corporation	Allentown Hospitality House Permanent Housing Program	PH-PSH	0
The Salvation Army, a New York Corporation	Salvation Army Carlisle PH Project	PH-PSH	0
Third Street Alliance for Women & Children	PA0811 Third Street Alliance Transitional Housing	TH	0
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing	PH-PSH	0
Transitions of PA	PA1139 Transitions of PA PSH for Snyder and Northumberland Counties	PH-PSH	0
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing Expansion	PH-PSH	0
Transitions of PA	PA0859 SUN Counties Transitional Housing for Survivors	TH	0
Transitions of PA	Transitions of PA Regional Transitional Housing for Survivors	DV TH	0
Transitions of PA	Transitions of PA Supportive Services Only for Survivors	SSO - Standalone	N/A
United Way of Pennsylvania	PA 0736 - Connect To Home Coordinated Entry Project	SSO-CE	N/A
United Way of Pennsylvania	PA1084 Enhanced East CES	SSO-CE	N/A
Valley Youth House Committee, Inc.	PA0887 - Lehigh Valley TH for Youth	TH	0
Valley Youth House Committee, Inc.	PA0808 - Lehigh Valley TH for families	TH	0
Women's Help Center	The Way Home Transitional Housing Project	TH	11
Women's Help Center	Cambria Somerset Supportive Services	SSO - Standalone	N/A

FY 2026

PA-509 Eastern Pennsylvania

Continuum of Care

**1C-3. Language from Project Supportive
Service Agreements**

Documents include the following:

- **Pages 2-4: Chart showing 100% of PA-509 TH, TH-RRH, PH-RRH & PH-PSH projects confirmed to require service participation**
- **Pages 5-135**
 - **Service Participation Agreements for each project**
 - **The Service Participation Agreement for VSPs accounts for other federal regulatory requirements for VSPs**

PA-509 CoC: 1C-3. List of TH/TH-RRH/RRH/PSH Projects that Require Program Participants to Take Part in Supportive Services

Number of TH, TH-RRH, PH-RRH, PH-PSH Projects:	50
Number of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	50
Percent of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	100%

Applicant Name	Project Name	Project Type	Requires Participation in Supportive Services?
Bradford County Human Service Agency	Transitional Housing Project 2026	TH	Yes
Breaking the Barriers	BTB Transitional Housing	TH	Yes
Catholic Social Services of the Diocese of Scranton, Inc.	PA0519-PSHP Pike County	PSH	Yes
Catholic Social Services of the Diocese of Scranton, Inc.	PA0386-Rural Permanent Supportive Housing	PSH	Yes
Catholic Social Services of the Diocese of Scranton, Inc.	PA0450-Susquehanna/Wayne PSHP	PSH	Yes
Center for Community Action	PA0372 Blair County TH	TH	Yes
Center for Community Action	PA0661 South Central TH	TH	Yes
Center for Community Action	PA1062 Rural Set Aside PSH Hardwoods	PSH	Yes
Center for Community Action	PA1138 Central Valley JMSU TH	TH	Yes
Centre County Government	PA0814 Centre County Transitional Housing Program	TH	Yes
Clinton County Housing Coalition	PA1063 Lincoln Apartments PSH SS Expansion	PSH	Yes
Clinton County Housing Coalition, Inc.	Lincoln Apartments	PSH	Yes
Clinton County Housing Coalition, Inc.	PA0966 Clinton County Transitional Housing Project	TH	Yes
Community CARES	Waypoint Transitional Housing	TH	Yes
County of Franklin	PA0649 - Franklin/Fulton S+C Project	PSH	Yes
Fitzmaurice Community Services, Inc	PA0214 - Pathfinders PSH	PSH	Yes
Housing Authority of the County of Cumberland	PA0447 - PSH Consolidated	PSH	Yes
Housing Authority of the County of Cumberland	PA0812 Transitional Housing	TH	Yes
Housing Development Corporation of NEPA	PA0384 HDC SHP 3 2026	PSH	Yes
Housing Development Corporation of NEPA	PA0582 HDC SHP 6 2026	PSH	Yes
Housing Transitions	PA0176 Nittany Housing Apartments Expansion	PSH	Yes

PA-509 CoC: 1C-3. List of TH/TH-RRH/RRH/PSH Projects that Require Program Participants to Take Part in Supportive Services

Number of TH, TH-RRH, PH-RRH, PH-PSH Projects:	50
Number of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	50
Percent of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	100%

Applicant Name	Project Name	Project Type	Requires Participation in Supportive Services?
Housing Transitions, Inc.	PA0176 Nittany House Apartments	PSH	Yes
Lebanon Rescue Mission	Safe Haven Partnership	DV TH	Yes
Monroe, County of	PA1087 - Pocono Mountains Transitional Housing Project FY2026	TH	Yes
New Bethany, Inc.	New Bethany Transitional Housing Project	TH	Yes
Northern Cambria Community Development Corporation	PA0360 Independence Gardens	PSH	Yes
Pennsylvania Coalition Against Domestic Violence	PA1088 Eastern PA CoC DV RRH Consolidation Renewal FY26	RRH	Yes
Pennsylvania Coalition Against Domestic Violence	PA1137 FY26 NEW Eastern PA CoC DV TH	TH	Yes
Perry Housing Partnership	PA0177 Perry Veterans SHP	PSH	Yes
Perry Housing Partnership	Perry County TH Program	TH	Yes
Resources for Human Development, Inc.	PA0449-Crossroads Housing Bonus Expansion	PSH	Yes
Schylkill Community Action Agency	Bridge House Transitional Housing	TH	Yes
Service Access and Management Inc.	PA1031 Daybreak Transitional Housing	TH	Yes
Tableland Services, Inc.	PA0705 Consolidated Permanent Supportive Housing with Disabilities	PSH	Yes
Tableland Services, Inc.	PA0366 Transitional Housing Project	TH	Yes
The Lehigh Conference of Churches	PA0222 - Pathways Permanent Supportive Housing Consolidation	PSH	Yes
The Lehigh Conference of Churches	Pathways II Permanent Supportive Housing	PSH	Yes
The Lehigh Conference of Churches	PA0222 Pathways Permanent Supportive Housing Consolidation Expansion	PSH	Yes
The Lehigh Conference of Churches	PA1029 - Pathways TH	TH	Yes
The Salvation Army, a New York Corporation	Allentown Hospitality House Permanent Housing Program	PSH	Yes
The Salvation Army, a New York Corporation	Salvation Army Carlisle PH Project	PSH	Yes

PA-509 CoC: 1C-3. List of TH/TH-RRH/RRH/PSH Projects that Require Program Participants to Take Part in Supportive Services

Number of TH, TH-RRH, PH-RRH, PH-PSH Projects:	50
Number of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	50
Percent of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	100%

Applicant Name	Project Name	Project Type	Requires Participation in Supportive Services?
Third Street Alliance for Women & Children	PA0811 Third Street Alliance Transitional Housing	TH	Yes
Transitions of PA	PA0859 SUN Counties Transitional Housing for Survivors	TH	Yes
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing	PSH	Yes
Transitions of PA	PA1139 Transitions of PA PSH for Snyder and Northumberland Counties	PSH	Yes
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing Expansion	PSH	Yes
Transitions of PA	Transitions of PA Regional Transitional Housing for Survivors	DV TH	Yes
Valley Youth House Committee, Inc.	PA0887 - Lehigh Valley TH for Youth	TH	Yes
Valley Youth House Committee, Inc.	PA0808 - Lehigh Valley TH for families	TH	Yes
Women's Help Center	The Way Home Transitional Housing Project	TH	Yes

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Bradford County Bridge Transitional Housing (BCBTH)**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

BCBTH is funded in whole or in part through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **BCBTH** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance use treatment or other recovery support services, then the program may require you to participate in substance use treatment or other recovery support services in order to stay enrolled in the program.

BCBTH provides the following supportive services to help participants obtain and retain permanent housing:

- **Employment readiness**
- **Financial literacy**
- **Mental health**
- **Physical health**
- **Treatment & recovery support services**
- **Independent living**
- **Services for intellectual and developmental disabilities and autism**
- **Educational enhancement**
- **Supportive services for families with children**

As a participant in **BCBTH**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **once a week for at least 30 minutes**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

For Transitional Housing Projects

- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

For Projects Requiring Substance Use Treatment

BCBTH is a treatment-focused program that requires all participants with identified substance use disorders to engage in substance use treatment and/or recovery support services, as appropriate. As a participant in **BCBTH** I agree to:

- ☐ Participate in the treatment, recovery support, counseling, peer support, medication-assisted treatment, or other services identified in my plan.
- ☐ Attend scheduled substance use treatment appointments, recovery meetings, counseling sessions, or other treatment or recovery-related services listed in my service plan.
- ☐ Notify program staff if I am struggling to access or maintain my treatment schedule.

☐ Tell program staff as soon as possible if I relapse, return to use, or believe I may be at risk of relapse, so staff can help me update my service plan, connect with treatment or recovery supports, and address any safety or housing concerns.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **BCBTH's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **BCBTH** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



Breaking the Barriers Transitional Housing SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Breaking the Barriers (BTB) Transitional Housing**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Breaking the Barriers (BTB) Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75(h)), participants in **BTB Transitional Housing** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

BTB Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

- ☐ Housing search and counseling
- ☐ Employment search and counseling
- ☐ Life skills and financial literacy development
- ☐ Obtaining vital records, like driver's licenses/IDs, birth certificates, social security cards
- ☐ Assistance with accessing benefits like SNAP, SSI/SSD, TANF - if you qualify
- ☐ Transportation assistance (like scheduling Healthrides or obtaining bus passes)
- ☐ Referrals to mental health, substance use, and primary care providers
- ☐ Referrals to legal support services, education services, child care services, food resources, and other assistance

As a participant in **BTB Transitional Housing** I agree to:

- ☐ Meet or communicate with my assigned case manager at least **twice weekly**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

If I have a disability that makes it difficult for me to meet **BTB Transitional Housing** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **BTB Transitional Housing** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review

meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

PA0519

PA0450

PA0386

Rural Permanent Supportive Housing
Susquehannah-Wayne PSHP
PSHP Pike County

Addendum to Catholic Social Services' Housing Program Agreements

I, _____ understand that participation in case management is required of all program participants, and for those not meeting age or disability exemptions, 20 hours per week of supportive services/employment/education/volunteering or some combination thereof will also be required. Supportive services are offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

1. Supportive services (Case Management) begin immediately upon entering a program. Case management is provided through "home visits" to allow all participants opportunity to engage.
2. Participation in the development of an Individual Service Plan is a program requirement. This ensures all participants' Individual Service Plan is based on each individuals' strengths, needs, preferences, and goals.
3. On-going assessments may lead to further supportive service referrals such as Drug and alcohol services (in-patient/outpatient), or mental health/behavioral services and evaluations. Client-accepted services become part of the Individual Service Plan.
4. Participants who choose to seek higher education or training in order to enhance personal growth or increase their earning potential, may reduce the employment/supportive services requirement proportionally.

Signature: _____

Date: _____

Case Manager: _____

Date: _____

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **PA0372 Blair County TH**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

PA0372 Blair County TH is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **PA0372 Blair County TH** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

PA0372 Blair County TH provides the following supportive services to help participants obtain and retain permanent housing:

- **Financial literacy (budgeting, avoiding predatory lending, bank accounts, etc.) HiSet tutoring (if needed to obtain diploma), intensive case management (assisting in addressing barriers, coordinating services), resume development, volunteering, cooking and nutrition classes, employment search (including preparing for interviews), individualized service plans with goal setting (developing goals-action steps-tracking progress), Prepared Renters Education Program (PREP), referrals to mental health services, referrals to substance use treatments, etc.**

As a participant in **PA0372 Blair County TH**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **weekly**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **PA0372 Blair County TH's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **PA0372 Blair County TH** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **PA0661 South Central TH**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

PA0661 South Central TH is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **PA0661 South Central TH** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

PA0661 South Central TH provides the following supportive services to help participants obtain and retain permanent housing:

- **Financial literacy (budgeting, avoiding predatory lending, bank accounts, etc.) HiSet tutoring (if needed to obtain diploma), intensive case management (assisting in addressing barriers, coordinating services), resume development, volunteering, cooking and nutrition classes, employment search (including preparing for interviews), individualized service plans with goal setting (developing goals-action steps-tracking progress), Prepared Renters Education Program (PREP), referrals to mental health services, referrals to substance use treatments, etc.**

As a participant in **PA0661 South Central TH**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **weekly**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **PA0661 South Central TH's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **PA0661 South Central TH** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **PA1062 Rural Set Aside PSH Hardwoods**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

PA1062 Rural Set Aside PSH Hardwoods is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **PA1062 Rural Set Aside PSH Hardwoods** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

PA1062 Rural Set Aside PSH Hardwoods provides the following supportive services to help participants obtain and retain permanent housing:

- **Financial literacy (budgeting, avoiding predatory lending, bank accounts, etc.) HiSet tutoring (if needed to obtain diploma), intensive case management (assisting in addressing barriers, coordinating services), resume development, volunteering, cooking and nutrition classes, employment search (including preparing for interviews), individualized service plans with goal setting (developing goals-action steps-tracking progress), Prepared Renters Education Program (PREP), referrals to mental health services, referrals to substance use treatments, etc.**

As a participant in **PA1062 Rural Set Aside PSH Hardwoods**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **weekly**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **PA1062 Rural Set Aside PSH Hardwoods's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **PA1062 Rural Set Aside PSH Hardwoods** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the

program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **PA1138 Central Valley TH**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

PA1138 Central Valley TH is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **PA1138 Central Valley TH** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

PA1138 Central Valley TH provides the following supportive services to help participants obtain and retain permanent housing:

- **Financial literacy (budgeting, avoiding predatory lending, bank accounts, etc.) HiSet tutoring (if needed to obtain diploma), intensive case management (assisting in addressing barriers, coordinating services), resume development, volunteering, cooking and nutrition classes, employment search (including preparing for interviews), individualized service plans with goal setting (developing goals-action steps-tracking progress), Prepared Renters Education Program (PREP), referrals to mental health services, referrals to substance use treatments, etc.**

As a participant in **PA1138 Central Valley TH**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **weekly**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **PA1138 Central Valley TH's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **PA1138 Central Valley TH** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Centre County Transitional Housing**. As part of this program, you are asked to participate in the supportive services offered to help you meet your basic needs. We will help your work toward safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Centre County Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75(h)), participants in **Transitional Housing** are expected to engage in supportive services that will help you maintain your current living situation, while working to toward safe and stable housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

Centre County Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

- ☐ Case Management including the development of an Individualized Service Plan that will feature your goals for housing and meeting basic needs and regular meetings to help you meet your goals.
- ☐ Referrals to services to assist you with your needs. These may include referrals for food, mental health services, medical services, and substance abuse counseling. They may also include referrals for childcare services, employment assistance, and mainstream benefits for health insurance and other benefits.
- ☐ Housing search and assistance acquiring resources for obtaining safe and stable housing.
- ☐ Other service needs you may have that are determined on a case by case basis.

As a participant in **Centre County Transitional Housing**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **bi-monthly**.

- ☐ Participate in regular case management or service planning focused on meeting basic needs, finding housing solutions, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

If I have a disability that makes it difficult for me to meet **Centre County Transitional Housing** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Centre County Transitional Housing** may consider further action under its written policies. If services are terminated, they may be continued at a later date.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

LINCOLN APARTMENTS PERMANENT SUPPORTIVE HOUSING PROJECT

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Lincoln Apartments Permanent Supportive Housing Project. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

The Lincoln Apartments Permanent Supportive Housing Project is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in the Lincoln Apartments Supportive Housing Project are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services to stay enrolled in the program.

Supportive Services

The Lincoln Apartments Permanent Supportive Housing Project provides the following supportive services to help participants obtain and retain permanent housing:

- Ongoing case management with CCHC Care Navigators to continually assess household needs, provide support as needs arise, and update the individualized service plan.
- Referral and connection to CareerLink to assist with resume building, job interviewing skills, mock interview practice, and assistance with applying to employment opportunities.
- Contacting Clinton County Assistance Office to help apply for SNAP benefits and Medicaid/Medicare if you do not currently receive benefits.
- Referral and connection to West Branch Drug & Alcohol for assistance with households in active addiction or recovery.

- Referral and connection to Lycoming-Clinton Mental Health and Intellectual Disabilities for beginning steps OR ongoing maintenance of mental health crises/emotional disturbances.
- Referral and connection to Center for Community Resources for blended case management with case manager at CCHC.
- Referral and connection to SKILLS of PA to assist households in need of skills building, empowerment building, resilience building.
- Referral and connection to Infant Development Program for households with young children in need of infant development.
- Referral and connection to Family Nurse Partnership for pregnant/first time mothers to help build parenting skills.
- Referral and connection to Salvation Army for free lunch services and the More Than Bread food program to address food insecurities.
- Connection to Salvation Army for volunteer needs to meet 20 hours/week service requirement if unable to fulfill.
- Referral and assistance with application to HeadStart program through STEP, Inc. to address any early learning and development needs.
- Referral and connection to Crossroads Counseling, Keystone Counseling, or other appropriate counseling services for ongoing mental health maintenance.
- Assist with referral to local healthcare systems including Geisinger, UPMC, River Valley Health and Dental, and the Dental Clinic to address healthcare needs.
- Communication with all service providers household is engaging with including Clinton County Domestic Relations, Probation, Children and Youth, and more to collaborate on the household's requirements with partner agencies.

Commitment

As a participant in the Lincoln Apartments Permanent Supportive Housing Project, I agree to:

- ☐ Meet or communicate with my assigned case manager at least monthly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Lincoln Apartments Permanent Supportive Housing Project service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, Lincoln Apartments Permanent Supportive Housing Project may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

Acknowledgement

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Name

Participant Signature

Date

CCHC Staff Name

CCHC Staff Signature

Date

CLINTON COUNTY TRANSITIONAL HOUSING PROJECT

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Clinton County Transitional Housing Project. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

The Clinton County Transitional Housing Project is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in the Clinton County Transitional Housing Project are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services to stay enrolled in the program.

Supportive Services

The Clinton County Transitional Housing Project provides the following supportive services to help participants obtain and retain permanent housing:

- Ongoing case management with CCHC Care Navigators to continually assess household needs, provide support as needs arise, and update the individualized service plan.
- Referral and connection to CareerLink to assist with resume building, job interviewing skills, mock interview practice, and assistance with applying to employment opportunities.
- Contacting Clinton County Assistance Office to help apply for SNAP benefits and Medicaid/Medicare if you do not currently receive benefits.
- Referral and connection to West Branch Drug & Alcohol for assistance with households in active addiction or recovery.

- Referral and connection to Lycoming-Clinton Mental Health and Intellectual Disabilities for beginning steps OR ongoing maintenance of mental health crises/emotional disturbances.
- Referral and connection to Center for Community Resources for blended case management with case manager at CCHC.
- Referral and connection to SKILLS of PA to assist households in need of skills building, empowerment building, resilience building.
- Referral and connection to Infant Development Program for households with young children in need of infant development.
- Referral and connection to Family Nurse Partnership for pregnant/first time mothers to help build parenting skills.
- Referral and connection to Salvation Army for free lunch services and the More Than Bread food program to address food insecurities.
- Connection to Salvation Army for volunteer needs to meet 20 hours/week service requirement if unable to fulfill.
- Referral and assistance with application to HeadStart program through STEP, Inc. to address any early learning and development needs.
- Referral and connection to Crossroads Counseling, Keystone Counseling, or other appropriate counseling services for ongoing mental health maintenance.
- Assist with referral to local healthcare systems including Geisinger, UPMC, River Valley Health and Dental, and the Dental Clinic to address healthcare needs.
- Communication with all service providers household is engaging with including Clinton County Domestic Relations, Probation, Children and Youth, and more to collaborate on the household's requirements with partner agencies.

Commitment

As a participant in the Clinton County Transitional Housing Project, I agree to:

- ☐ Meet or communicate with my assigned case manager at least monthly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet [Program Name's] service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, [Program Name] may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

Acknowledgement

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Name

Participant Signature

Date

CCHC Staff Name

CCHC Staff Signature

Date

COMMUNITY CARES HOMELESS SERVICES

The Waypoint Transitional Housing Participant Agreement*HUD Continuum of Care Transitional Housing Project | Cumberland County***Participant name****HMIS or client ID****Program entry date****Assigned case manager****Purpose and funding**

The Waypoint is operated by Community CARES and funded in whole or in part through the U.S. Department of Housing and Urban Development Continuum of Care Program as a Transitional Housing project. The program provides temporary housing and individualized services designed to help participants move to safe, stable permanent housing. This service agreement is separate from the lease, sublease, or occupancy agreement.

Housing charges. This agreement does not establish a flat monthly fee, rent, an occupancy charge, or a mandatory savings deposit. Any participant contribution permitted under the approved grant will be calculated and explained separately under HUD requirements and Community CARES written policy.

Support available

- ☐ Housing search, applications, landlord communication, reasonable-accommodation support, and move-in planning.
- ☐ Individualized case management and a Housing Stability and Service Plan.
- ☐ Employment assessment, job search, resumes, interviews, workplace readiness, and job-retention support.
- ☐ Continuing education, GED services, vocational training, certifications, apprenticeships, and employer connections.
- ☐ Benefits, budgeting, tenancy skills, transportation planning, child-care connections, and other community resources.
- ☐ Voluntary medical, mental-health, substance-use recovery, legal, disability, and peer-support referrals.

My participation

I agree to make a good-faith effort to:

- ☐ Meet or communicate with my case manager at least weekly using an agreed method.
- ☐ Create a Housing Stability and Service Plan within 14 days of enrollment and review it at least monthly.
- ☐ Work on reasonable steps connected to housing, income, benefits, education, employment, health, or other goals that apply to me.

- ☐ Participate in housing search and provide documents reasonably needed to verify eligibility, calculate any permitted contribution, and pursue housing.
- ☐ Notify staff when I cannot attend and work with staff to reschedule or adjust my plan.
- ☐ Follow the separate occupancy agreement and safety expectations for the residence.

Weekly engagement requirement

The Waypoint will provide or arrange individualized services intended to result in at least 20 hours each week of employment, services, or approved activities. Paid employment counts. Other activities may include case management, housing search, continuing education, job training, certification programs, benefits appointments, volunteering, life-skills work, community-building activities, and mental-health or recovery services I voluntarily choose and include in my plan.

Participation status: ☐ Requirement applies ☐ Participant is over age 62 ☐ Applicable disability exemption or accommodation

Weekly plan or documentation method:

Voluntary health and recovery services

Mental-health counseling, outpatient health care, medication, disability-related services, and substance-use treatment or recovery services are voluntary because The Waypoint is not a treatment program. Declining treatment, returning to substance use, or having a disability does not by itself end program assistance. Separate conduct or safety concerns will be addressed under the occupancy agreement and written policies.

When participation becomes difficult

Staff will attempt to understand barriers and help me re-engage. Options may include reminders; a different worker, meeting time, location, or format; transportation or communication assistance; a revised plan; an exemption review; or a reasonable accommodation. One missed appointment or one week below 20 hours does not automatically terminate assistance.

Program action and due process

Ongoing refusal to participate in required, non-disability-related services may lead to corrective action under written policy after reasonable engagement efforts. Before an involuntary termination, except for immediate steps needed to address a serious health or safety threat, Community CARES will provide:

- ☐ Written notice stating the reason and proposed effective date.
- ☐ An opportunity to present written or oral objections.
- ☐ Review by a person who did not make or approve the original decision and is not subordinate to that decision-maker.
- ☐ Prompt written notice of the final decision and available grievance or appeal rights.

My rights and privacy

- ☐ I may request a reasonable accommodation, language assistance, or effective communication at any time.
- ☐ I will not be discriminated against or retaliated against for requesting help or using the grievance process.
- ☐ Information will be collected and protected under Community CARES privacy practices and applicable HMIS policy. Staff will explain separate privacy, consent, and release forms.
- ☐ Service decisions will be based on documented eligibility, needs, preferences, and goals rather than assumptions about my identity, disability, health, family, or history.

Acknowledgment

By signing, I confirm this agreement was reviewed with me in a way I understand, I could ask questions, and I received or was offered a copy. My signature does not waive any legal right.

Participant signature

Date

Community CARES staff signature

Date

Interpreter or representative if applicable

Date

COMMUNITY CARES HOMELESS SERVICES REST | REASSURANCE | RESOURCES

Participant-facing universal agreement

Universal Participant Services, Rights & Responsibilities Agreement

Use across Community CARES programs. Program-specific addenda or occupancy/financial-assistance agreements control when more specific requirements apply.

Important: This agreement creates a common baseline for Community CARES services. It is designed to remain usable when the program or funding source changes. It does not replace a program-specific addendum, shelter rule, lease/occupancy agreement, financial-assistance agreement, HMIS consent, release of information, or other document required for a particular service.

Participant name / identifier

HMIS / Client ID/Charity Tracker (if applicable)

Date reviewed

Emergency Contact

Primary program / service

Other CARES program(s)

1. Purpose and Funding

Community CARES provides shelter, outreach, housing-focused services, prevention/diversion assistance, resource-center services, transitional housing, and other supports. Services may be paid for by federal, state, local, health-system, foundation, charitable, private, or Community CARES unrestricted funds.

The funding source may determine eligibility, allowable costs, documentation, length of assistance, and other requirements. Community CARES will document the correct program and funding source in the participant file. A change in funding source does not by itself change this universal agreement unless a program-specific requirement changes.

- ☐ I understand that signing this agreement does not guarantee shelter, housing, financial assistance, a particular benefit, or funding from a specific source.
- ☐ I understand that I may be asked to sign a separate program addendum or assistance/occupancy agreement when a program has additional requirements.

2. What Community CARES Will Do

- ☐ Provide services in a respectful, person-centered manner and explain the program or service being offered.
- ☐ Use the least intrusive information needed for eligibility, service coordination, safety, required reporting, and payment documentation.
- ☐ Explain program-specific participation expectations before they are enforced.

- ☐ Offer reasonable accommodation, language assistance, or effective communication when needed and required by law.
- ☐ Explain applicable privacy/HMIS notices and obtain separate consent or releases when required.
- ☐ Provide information about grievances, program review, and appeal rights when applicable.
- ☐ Make reasonable efforts to reconnect, problem-solve, or adjust the service approach when participation becomes difficult.

3. What I Agree to Do

- ☐ Provide information that is accurate to the best of my knowledge and documents reasonably needed for eligibility or a specific assistance request.
- ☐ Tell staff about important changes that may affect my eligibility, safety, household, income, housing, contact information, or service plan when reasonably possible.
- ☐ Work with staff on the reasonable, non-disability-related participation expectations that apply to the specific program in which I am enrolled.
- ☐ Tell staff when an appointment, referral, activity, or plan is not workable so another approach can be considered.
- ☐ Treat staff, participants, volunteers, neighbors, and partners without threats, violence, harassment, or conduct that creates a serious safety risk.
- ☐ Follow the separate safety, shelter, occupancy, property, or financial-assistance rules that apply to the service or location I am using.

4. Substance Use, Treatment and Recovery

Community CARES does not use sobriety or participation in substance-use treatment as a blanket prerequisite for services. A specific project may have different legally permitted requirements only when those requirements are clearly stated in that project's approved rules and addendum.

Mental-health treatment, outpatient health care, medication, disability-related services, and substance-use treatment or recovery services are voluntary unless a specific project is expressly designed and legally permitted to require a treatment service. The Community CARES programs covered by the Street Outreach/Housing Connections and Waypoint addenda are not described as treatment-focused projects.

- ☐ Declining voluntary treatment, disclosing substance use, or experiencing relapse/return to use does not by itself result in denial or termination of Community CARES assistance.
- ☐ When I want help with substance use or recovery, staff may offer information, peer/recovery supports, referrals, service coordination, and warm handoffs to qualified providers.
- ☐ Community CARES does not knowingly permit illicit-drug use or distribution on property it owns, leases, or controls, and program funds will not be used to distribute illicit-drug paraphernalia.
- ☐ While on Community CARES property, I must follow applicable law and site-specific safety, medication, conduct, shelter, and occupancy rules. Lawfully prescribed medication is not considered an illicit drug under this agreement.
- ☐ If a contact becomes unsafe because of behavior, impairment, violence, threats, or another immediate risk, staff may pause, relocate, or end that contact and will attempt to reconnect or offer a safer alternative when reasonably possible.

5. Privacy, HMIS and Information Sharing

- ☐ Community CARES may document enrollment, contacts, services, referrals, assistance, and outcomes in HMIS or another required system when applicable.
- ☐ Staff will explain the applicable privacy notice and any separate release-of-information or consent forms.
- ☐ Information will be shared only as permitted by law, program rules, consent, or a documented safety/legal exception.
- ☐ I may ask questions about information collected about me and may request correction of inaccurate information according to applicable policy.

6. Accessibility, Choice and Grievances

- ☐ I may request a reasonable accommodation, language assistance, interpreter, accessible communication, or another reasonable way to participate.
- ☐ I may ask questions, raise a concern, or use the Community CARES grievance process without retaliation.
- ☐ Where a funding source or program requires a formal termination process, Community CARES will provide the notice and review rights required for that program.
- ☐ My signature does not waive any legal right and does not require me to accept medical, mental-health, substance-use, religious, or other optional services.

Acknowledgment

By signing, I confirm that this agreement was reviewed with me in a way I understand, I had the opportunity to ask questions, and I received or was offered a copy. I understand that program-specific addenda or other agreements may apply to particular Community CARES services.

Participant signature

Date

Community CARES staff signature

Date

Interpreter / representative (if applicable)

Date

COMMUNITY CARES HOMELESS SERVICES

REST | REASSURANCE | RESOURCES

Program-specific addendum to the Universal Participant Agreement

The Waypoint Transitional Housing Service Participation Addendum

HUD Continuum of Care Transitional Housing Project | Cumberland County

Important: Use this addendum with the Community CARES Universal Participant Services, Rights & Responsibilities Agreement and the separate Waypoint lease, sublease, or occupancy agreement. This service addendum does not create rent or an occupancy charge and does not replace housing rules.

Participant name

HMIS / Client ID

Program entry date

Assigned case manager

1. Purpose of The Waypoint

The Waypoint is a Community CARES Transitional Housing project designed to provide temporary housing and individualized supportive services that help participants move to safe, stable permanent housing and increase self-sufficiency. Services are person-centered and based on the participant's strengths, needs, preferences, abilities, and goals.

2. Supportive Services Available

- ☐ Housing search, applications, landlord communication, reasonable-accommodation support, tenancy preparation, and move-in planning.
- ☐ Individualized case management and a Housing Stability and Service Plan.
- ☐ Employment assessment, job search, resumes, interviews, workplace readiness, and job-retention support.
- ☐ Continuing education, GED services, vocational training, certifications, apprenticeships, and employer connections.
- ☐ Benefits access, budgeting, tenancy skills, transportation planning, child-care connections, and mainstream resources.
- ☐ Voluntary medical, mental-health, substance-use treatment/recovery, legal, disability, and peer-support referrals or warm handoffs.
- ☐ Other eligible supportive services identified in the individualized plan and available through Community CARES or partner organizations.

3. Required Participation and Individualized Plan

As a Waypoint participant, I agree to participate in the project's required non-disability-related supportive services and approved engagement activities, subject to the exceptions and accommodations described below.

- ☐ Meet or communicate with my assigned case manager at least weekly using an agreed method, unless my individualized plan or an approved accommodation provides another arrangement.
- ☐ Create a Housing Stability and Service Plan within 14 days of enrollment and review it at least monthly.
- ☐ Work on reasonable steps connected to permanent housing, income, benefits, education, employment, independent living, or other goals that apply to me.
- ☐ Participate in housing search and provide documents reasonably needed to verify eligibility, determine any permitted contribution, and pursue housing.
- ☐ Notify staff when I cannot attend or complete a planned activity and work with staff to reschedule, revise, or document the plan.
- ☐ Follow the separate Waypoint occupancy agreement and safety expectations for the residence.

4. Weekly Engagement Requirement

Waypoint will provide or arrange individualized services intended to result in at least 20 hours each week of engagement in services, activities, or employment for participants to whom the requirement applies. Paid employment counts toward the 20 hours.

Approved activities may include case management, housing search, paid employment, job search, education, vocational training, certification programs, apprenticeships, benefits appointments, budgeting/tenancy education, volunteering, life-skills work, community-building activities, and other approved steps in the participant's plan. Voluntary mental-health or recovery services chosen by the participant may count toward the weekly hours.

The 20-hour requirement does not apply to a participant over age 62 or to a participant who meets the applicable FY2026 CoC exception for an individual with handicaps under 24 CFR 8.3 or a developmental disability under 24 CFR 578.3. Community CARES will also consider reasonable-accommodation requests required by applicable law.

Participation status

- ☐ 20-hour requirement applies ☐ Over age 62 ☐ Applicable disability exception / accommodation

Weekly plan / documentation method

Primary employment / service activity

Next plan review

5. Substance Use, Treatment and Recovery

The Waypoint is not a substance-use treatment program and is not designated as sober housing. A participant is not required to be sober or participate in substance-use treatment as a condition of admission to The Waypoint.

- ☐ Substance-use disorder treatment, recovery services, peer recovery support, counseling, medication-assisted treatment, mental-health care, outpatient health care, medication, and other disability-related clinical services are voluntary.
- ☐ If I choose treatment or recovery services and include them in my individualized plan, Community CARES may help coordinate the service and the activity may count toward my weekly engagement hours.

- ☐ Declining treatment, disclosing substance use, or experiencing relapse/return to use does not by itself end Waypoint housing or program assistance.
- ☐ Community CARES does not knowingly permit illicit-drug use or distribution on property it owns, leases, or controls and does not use program funds to distribute illicit-drug paraphernalia.
- ☐ Participants must follow applicable law and the separate Waypoint occupancy, medication, safety, and conduct rules. Lawfully prescribed medication is not considered an illicit drug under this addendum.
- ☐ When substance use creates a health, safety, housing, or engagement concern, staff will seek to engage the participant, offer voluntary treatment/recovery resources, consider reasonable accommodation when applicable, and use documented problem-solving before considering termination, except when immediate safety action is necessary.

6. When Participation Becomes Difficult

Staff will attempt to understand barriers and help the participant re-engage. Options may include reminders; a different worker, meeting time, location, or format; transportation or communication assistance; a revised weekly plan; an exception/accommodation review; referral; or another reasonable support.

One missed appointment or one week below 20 hours does not automatically terminate assistance. Ongoing refusal to participate in required non-disability-related services or activities may lead to corrective action under written policy only after reasonable re-engagement efforts and consideration of applicable exceptions or accommodations.

7. Program Action and Due Process

Program assistance may be ended only under Community CARES written policies, the separate Waypoint occupancy agreement, and applicable law. For an involuntary termination from CoC-funded assistance, Community CARES will provide:

- ☐ A written copy of applicable program rules and the termination process before assistance begins or as otherwise required.
- ☐ Written notice clearly stating the reason for the proposed termination.
- ☐ An opportunity to present written or oral objections before a reviewer who did not make or approve the original decision and is not subordinate to that decision-maker.
- ☐ Prompt written notice of the final decision and information about available grievance or appeal rights.

Termination from Waypoint does not permanently bar Community CARES from providing assistance later and does not prevent the participant from seeking assistance from another program.

8. Participant Rights

- ☐ I may request a reasonable accommodation, language assistance, interpreter, or effective communication support.
- ☐ I will not be retaliated against for requesting help, an accommodation, or using the grievance process.
- ☐ Service decisions will be based on documented eligibility, program requirements, needs, preferences, and goals rather than assumptions about disability, diagnosis, substance use, family status, or history.
- ☐ I may ask questions about this addendum and receive or be offered a copy.

Acknowledgment

By signing, I confirm that the Community CARES Universal Participant Agreement, this Waypoint addendum, and the separate occupancy rules were reviewed with me. I had the opportunity to ask questions and

received or was offered copies. My signature does not waive any legal right or require me to accept voluntary medical, mental-health, or substance-use treatment.

Participant signature _____ Date _____ CARES staff signature _____ Date _____

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

PURPOSE OF THE MANUAL

This manual is designed to provide individuals who are participating in the program the information necessary to understand:

- *The eligibility and criteria for you to be a program participant.*
- *Any requirements of the program that you must complete.*
- *How the supportive housing program can and will assist you through the services that are offered.*

Program participants should review this manual to ensure their complete understanding of the supportive housing program.

INTRODUCTION

Franklin County Supportive Housing Program (FCSHP) is a federal program funded by the US Department of Housing and Urban Development (HUD) and operated by the Community Connections Division of the Franklin County Government. The FCSHP was established to assist eligible homeless individuals with affordable permanent housing through the provision of a rental subsidy and supportive services. Following the Housing First model, you are encouraged to access the supportive services offered through us and our community partners. However, participation in supportive services is not a requirement to receive housing assistance.

Program staff will encourage you to:

- Work towards stability and independence by developing short- and long-term goals.
- Assist you with your housing related needs.
- Assist in connecting you with community resources to fill the void of any need that is identified and not provided by the FCSHP.

To be a participant in this program, you must meet the eligibility criteria of chronic homelessness and have an identifiable disabling condition. You will be asked to participate in the search for your housing to ensure it meets your needs. Any apartment or home identified by you must be in the FCSHP service area, pass a housing quality inspection, and meet the fair-market rent guidelines for the county.

A HOUSING FIRST APPROACH IS USED

Housing First is a proven approach that can benefit both homeless families and individuals with any degree of service need(s) by swiftly connecting them to permanent housing. Access to FCSHP is not contingent on sobriety, minimum income requirements, lack of a criminal record, completion of treatment, participation in services, or other unnecessary barriers.

Housing First and Supportive Housing are practiced as complementary tools for each other to assist in ending chronic homelessness and provide supports to gain stability while allowing you to live independently in a community of your choice.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

Franklin County operates its supportive housing programs using the Housing First approach from the date of entry until exit; ensuring that you will:

- Gain access to housing that fits your needs quickly and efficiently, thereby removing you from homelessness in a rapid manner.
- Not be screened out of entry due to lack of sobriety, criminal background, income or other unnecessary barriers that can keep you homeless.
- Be able to focus on your recovery as you work towards stability and independence.
- Allow for you to access and use voluntary services that best fit you based on your needs.

WHAT MAKES YOU ELIGIBLE?

The FCSHP was established to assist eligible homeless individuals with affordable permanent housing. Eligibility guidelines include:

- (1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
 - a. Has a primary nighttime residence that is a public or private place not meant for human habitation; or
 - b. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
 - c. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; or
 - d. Is fleeing, or is attempting to flee, domestic violence; has no other residence; and lacks the resources or support networks to obtain other permanent housing.
- (2) A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual's ability to work or perform one or more activities of daily living.
- (3) Prioritization for individuals that are chronically homeless, defined as being homeless for 12 consecutive months or on (4) four occasions in the last (3) three years cumulatively totaling at least 12 months.

ARE THERE REQUIREMENTS TO PARTICIPATE?

There are very few requirements to participate in this program as our goal is to provide a program that has very few barriers.

As a participant in this program, you ARE REQUIRED to:

- Provide proof of disability within 45 days of your enrollment. This can be completed by providing a copy of your most recent social security awards letter or having a doctor complete the Verification of Disability Form.
- Provide proof of homelessness within 45 days of your enrollment. This is provided when you identify others in the community that was aware of your homelessness. Staff will contact those identified to receive the appropriate documentation.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

- Meet with FCSHP staff for case management. Based on the your needs, case management meetings can occur every two (2) weeks up to one (1) time every six (6) weeks. There are no requirements as to the length that a meeting must be held. Meetings are conducted in one of the following manners:
 - In Person (Face-to-Face) Meeting
 - Virtual Meeting (Zoom, Google, etc.)
 - Phone Meeting

Individuals who are selected for this program ARE NOT REQUIRED to:

- Have income for payment of the monthly utilities and/or a portion of their rent which is equal to 30% of the individual's adjusted gross income.
- Be sober or complete a treatment program.
- Lack a criminal record.
- Participate in supportive services or any other unnecessary barriers.

WHY WAS I CONSIDERED FOR THIS PROGRAM?

To be considered for this program, you had to complete the Coordinated Entry Connect to Home process with a placement on the By Name List (BNL). Individuals with the highest score and who met the eligibility requirements were considered for intake and enrollment into the program. Leasing and supportive services are then provided to those approved for enrollment.

WHERE DO THE RULES FOR THIS PROGRAM COME FROM?

The FCSHP follows the policies, guidelines, and requirements set by the Continuum of Care (CoC) Regulation 578.23 and other applicable HUD regulations. You should understand that these policies, guidelines and requirement are subject to change and may result in the way that the program works being changed. Failure to the policies, guidelines, and requirements may result in actions by HUD, to include recapture of assistance awarded to the program. Because of this, you will be notified promptly of any changes that will affect you.

WHAT DOES THE PROGRAM CONSIST OF?

The program has five (5) main components that work for you. They are:

- Program Enrollment
- Leasing Assistance
- Case Management
- Supportive Services
- Operating Assistance

The following section of this manual will provide you with a better understanding of each of these components.

Program Enrollment And Documentation

As found in the "WHY WAS I CONSIDERED FOR THIS PROGRAM?" section of the manual, individuals are identified for this program through the use of the CoC Coordinated Entry Connect to Home process. When you are contacted it was with the intent to establish an intake appointment to determine that

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

you meet the eligibility requirements as outlined in the “WHAT MAKES YOU ELIGIBLE?” section of the manual.

At intake, it is determined as to whether you met the eligibility or not. It is at this meeting that the start of your journey to become housed begins. FCSHP staff will start the process of obtaining verification documents on your behalf. These documents are required as proof of your homelessness and disability. FCSHP staff will have forty-five (45) days to obtain any required verification documents which is why your help with this process is important.

Failure to obtain documentation in this timeframe does not make you ineligible. FCSHP staff can request that you provide:

- Your own accounting of homelessness.
- A Verification of Disability form completed by an authorized medical provider of their choice.

During the time that we are working to secure documentation, we start the process of securing housing that fits the needs your needs. This is done even if you are **not document ready**. Once housing is secured, you will then be established with case management staff to work on your housing related needs.

If you are unwilling to provide documentation or obtain the Verification of Disability after ninety (90) days, then the FCSHP staff will be required to start the termination of assistance process. Referrals to other services will be made to assist you to stay in your apartment.

Leasing Assistance

FCSHP provides leasing assistance (aka rental subsidies or monthly rent) directly to the landlord in full. This eliminates the risk of a landlord not receiving the money owed to them and a potential eviction to occur. Although the program pays the rent in full to your landlord, **you are responsible to pay your portion of the rent** back to the program.

Determining what your portion of the rent will be is done based on your income. To determine this, we use of the HUD Tenant Rent Calculation Worksheet. The worksheet also provides us the ability to determine if you are eligible for any additional income allowances and exclusions. It is noted that your portion of the rent MUST be the HIGHER AMOUNT of either 30% of the adjusted monthly income or 10% of the gross monthly income.

The details of your rental payments are then outlined in a “Payment of Rent Agreement” which is entered into with the participant and attached to a copy of your lease. In addition, you will sign a Tenant Housing Program Agreement form outlining additional responsibilities under the FCSHP program.

In addition to the monthly leasing assistance, the program pays your security deposit and/or first/last month’s rent. The security deposit, first month’s rent, and/or last month’s rent is paid directly to the landlord. Security deposits are returned to the program when you vacate the apartment you live in.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

Case Management

Case management is provided by FCSHP staff. Case management focuses on your needs that are related to housing. Case management may also offer or recommend other supports or services outside of the scope of housing.

You are required to meet with FCSHP staff for case management. Based on the your needs, case management meetings can occur every two (2) weeks up to one (1) time every six (6) weeks. There are no requirements as to the length that a meeting must be held. Meetings are conducted in one of the following manners:

- In Person (Face-to-Face) Meeting
- Virtual Meeting (Zoom, Google, etc.)
- Phone Meeting

Supportive Services

Supportive services are offered to empower you to live as independently as is practicable throughout the duration of your residence in the project. You are not required to obtain or use the supportive services that are offered as all supportive services are voluntary.

These are a just few of the supportive services that are available.

- *Mental health case management*
- *Peer support services*
- *Education services*
- *Employment assistance and job training*
- *Food*
- *Housing search and counseling services*
- *Legal services*
- *Life skills training*
- *Mental health services*
- *Outpatient health services*
- *Substance abuse treatment services*
- *Transportation*

If you do not see a service that may help you, we encourage you to ask case management if it is available.

Operating Assistance

Operating assistance allows for the program to assist clients with utility deposits, moving assistance and to ensure your apartment has basic furniture in it.

Utility deposits are paid on behalf of the client directly to the utility company providing the service to your home. Utility deposits will stay with the program and cannot be transferred over to you.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

Furniture is provided for all apartments that are in the program. **Furniture is the property of the program and will stay with the program.** When you move in to your apartment, these are the pieces of furniture that you may find.

- Full size bed comprised of a frame and a new mattress
- Couch
- Kitchen Table and Chairs
- Dresser
- Pots and pans

If an item is not in the unit, we may need to order this. However, this is based on availability of program funds and may have to wait until funds become available to make the purchase. When you leave the apartment or exit from the program the items listed above; with the exception of your mattress; will remain in the apartment.

HOW IS HOUSING FOUND AND APPROVED?

Housing Search Assistance

Once your enrollment is completed and you are now participating in the program, FCSHP staff will assist you in identifying the housing that best fits your needs. Once it is determined what you prefer, the housing search begins.

FCSHP staff will provide you with information as to what price range you can look for housing in as it determined by the Fair Market and Rent Reasonable regulations which HUD has set for the program to use.

FCSHP staff will ensure that apartments are accessible for those with disabilities and that they comply with Americans with Disabilities Act (ADA) standards as needed. When housing it found that meets these standards, the next step will be to have an inspection completed.

Housing Quality Inspections Including Lead

Before Leasing Assistance is approved, a unit must meet applicable housing quality standards including inspection for lead. To assure housing quality standards are met, a visual inspection will be completed by FCSHP staff.

Inspections are completed at the following timeframes:

- Apartments new to the program
- Between tenants for apartment already established with the program
- Annually at lease time

A section for lead-based paint is included in the housing inspection checklist. When looking for lead-based paint, a visual inspection is the key to ensure all painted surfaces are free of deteriorated paint. If they are not, it needs to be determined if the surfaces exceed two square feet per room and/or is more than 10% (de minimis level) of a component. If the surfaces exceed the two square feet, remediation must occur. It is the responsibility of the property owner to:

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

- Protect the residents and their belongings
- Repair substrate damage
- Repair the paint
- Conduct cleanup
- Deal with other LBP-related concerns
- Obtain clearance (if deteriorated surface is more than the de minimis)

Before approval of the unit can occur, another visual inspection and clearances, if necessary, must be obtained that the remediation was completed before approval of the unit can occur.

For units that pass the visual lead-based paint inspection, the pamphlet “Protecting Your Family from Lead-Based Paint will be provided to you. The Disclosure of Information on Lead-Based Paint and/or Lead-Based Paint Hazards is then signed by the Landlord, Tenant, and you as the Subtenant.

Leasing assistance will not be provided for units that fail the HQS, unless deficiencies are corrected by the unit owner within 30 days and FCSHP staff verifies that the deficiencies are corrected.

Lease

Once the unit passes inspection, a formal lease will be established. Leasing terms are for one (1) year (ex: April 1, 20XX to April 1, 20XX) and are renewable at the end of the lease unless a thirty (30) day notice is given by any of the parties not to renew. Leases are signed by you (Subtenant), Landlord, and County Administration (Tenant). Once a lease is fully executed, you will receive a copy for your records.

NOW THAT I AM HOUSED, WHAT CAN I EXPECT NEXT?

Now that housing has been secured, you will start the process of meeting with the case management staff to work on your housing related needs. However, there is one item that will occur on an annual basis. It is:

Annual Assessments of Service Needs

Annual assessments of service needs are used to identify any possible service gaps, housing-related barriers, and what level of case management you may need. Assessments will be completed annually on the date of your program enrollment.

The Annual Assessment of Service Needs will include questions that allow the updating of your records for income, mainstream benefits and insurance, disability, and emotional health.

HOW AND WHY WOULD I BE EXITED FROM THE PROGRAM?

FCSHP staff continuously plan for the closing of your services so that it provides a timeframe which will allow for the appropriate supports to be in place allowing you to be able to maintain your housing stability.

We expect to experience positive exits, non-responsive exits, and negative exits which will require a termination of assistance.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

Positive Exits

Your file may be closed at any time that it is determined that you are no longer at risk of homelessness. Determining if you are at risk of homelessness is a process that takes into consideration the following factors:

- Have you gained/increased employment or cash income
- Have you gained/increased non-cash benefits
- Have you gained or have access to other supports that will assist in maintaining your housing stability (supports of family and friends, Housing Choice Vouchers, income-based / rent subsidized unit, etc.)
- You have demonstrated the ability to pay your rent and follow the requirements of the lease

Non-Responsive Exits

When you no longer are responsive to staff, it may be necessary to exit you from the FCSHP. Every effort will be made to re-engage with you before an exit occurs. FCSHP staff are required to attempt contact with you no less than five (5) times during a sixty (60) day timeframe. The attempted contacts will occur through the use of:

- Phone
- Mail
- Email
- Text
- Home Visit

Three different methods of contact will be used with one of them being a home visit. Any mailings will be sent via Certified Mail with restricted delivery and also through regular USPS mail. Each attempted contact is recorded in your case file. Copies of any mailings are required to be placed into your case record as well.

In the event that these attempts are unsuccessful, and as a last effort, FCSHP staff will attempt to connect with the emergency contact that has been identified in your file. This can be completed only if a valid release of information has been signed by you. If there is no signed release, then the emergency contact WILL NOT BE contacted.

At this point, FCSHP staff will then start the termination of assistance process. A letter will be sent via certified mail and regular USPS mail including each of the following:

- Reason for the communication which includes the pending termination of assistance
- Outline of the attempts to contact you
- Date that the termination will occur (no less than 30 days from date of mailing)
- Appeals Policy

Additionally, FCSHP staff will contact the landlord to notify them of the pending termination of assistance.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

If you contact the FCSHP after the date of your termination, you will be directed to the Connect to Home Coordinated Entry System to obtain the services that best fit you.

Negative Exit/Termination of Assistance

Termination of assistance can occur when repeated notice has been provided for non-payment of rent, damaging the unit, harassment of other tenants, criminal activities, or the continued violations of the lease. **SUBSTANCE USE OR NON-PARTICIPATION IN SUPPORTIVE SERVICES IS NOT GROUNDS FOR EXITING YOU.** FCSHP staff will address and attempt to resolve any of these issues before a termination is completed. All attempts to address these issues are recorded into your case file. Terminations of assistance are assessed on a case-by-case basis, with an emphasis on evaluating all extenuating circumstances and terminating only in the most severe cases. If we are unable to resolve the issue with you and there are no extenuating circumstances, an exit will take place.

You will be granted your right to Due Process and to Appeals. A letter will be sent via certified mail and regular USPS mail including each of the following:

- Reason for the communication which includes the pending termination of assistance
- Outline of the attempts to contact you
- Date that the termination will occur (no less than 30 days from date of mailing)
- Appeals Policy

Additionally, FCSHP will contact the landlord to notify them of the pending termination of assistance. **IF YOU APPEAL THE DECISION, ALL FINANCIAL ASSISTANCE WILL REMAIN IN PLACE UNTIL THE APPEALS PROCESS HAS BEEN COMPLETED.**

If you contact the FCSHP after your date of termination, you will be directed to the Connect to Home Coordinated Entry System to obtain the services that best fit you. If assistance has been terminated, you may reapply to the program when you meet eligibility again.

Eviction from Unit

Eviction from a unit does not necessitate an exit from the program. Every attempt to resolve the reason for an eviction will be conducted. If there is no resolution available, the FCSHP staff will work with you to identify and obtain new housing that meets your needs.

In the event that the eviction requires an exit from the program, FCSHP staff will follow the guidelines as provided under the *Negative Exit/Termination of Assistance* section above.

ARE THERE ADDITIONAL POLICIES THAT I SHOULD KNOW ABOUT?

Abandonment of Items and Notice Of Intent

The FCSHP recognizes that there are times that you may move or vacate apartments and leave items behind. When this occurs, the items left behind need to be handled in an appropriate manner to ensure that the rights of you and the landlord are met. You and FCSHP staff will provide at least a thirty (30) day notice that a unit is being vacated to the landlord. It is understood that you must ensure all items are removed from the unit. If the landlord has accepted possession of the unit, any items left

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

behind are then subject to a ten (10) day timeframe to be removed. If items are not removed, it then becomes the responsibility of the landlord and program staff to determine what occurs to your belongings.

Termination of Assistance, Grievances and Appeals

FCSHP recognizes that you have the right to ensure your grievances are heard as well as appeal a decision that has been made by the FCSHP. In order to ensure this right, you are provided a copy of the grievance and appeal policy at intake as it is a part of the program participant manual. This policy addresses your rights and the process to place a grievance or appeal a decision of the program.

The policy is as follows:

Termination of Assistance to Participants, Grievances and Appeals Policy

Termination of assistance will be assessed on a case-by-case basis, with an emphasis on evaluating all extenuating circumstances and terminating only in the most severe cases. Reasons for terminating are clearly outlined in the regulations contained in HUD 24CFR Termination of Assistance to Participants, sections C 582.320. All participants will be granted rights to Due Process and to Appeals. Any participant whose assistance has been terminated may reapply to the program when eligible.

Grievances are an official statement of a complaint over something believed to be wrong, unfair, or unethical. Individuals can file grievances for any of the following reasons:

- Poor customer service
- Slow response time
- Service inconsistency
- Ethical concerns

This list is not exhaustive. We will make every attempt possible to resolve your issue, but if you feel that it is not able to be done, a formal grievance should be completed.

Appeals are a formal process which will allow you to ask for a decision to be reviewed and reconsidered. Appeals are time-restricted as outlined below. Appeals can be made in either a written or oral format to the Community Connections management for processing.

PROCEDURES FOR TERMINATION OF ASSISTANCE, GRIEVANCE AND APPEALS:

Termination of Assistance:

- (1) All participants are granted recognition of their rights and due process in termination determinations, as follows:
 - (a) Written notice will be sent to the participant containing a clear statement of the reasons for termination and a timeline for them to vacate the premises. This notice will be sent via

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

certified mail and regular USPS mail. (Timing of the Notice will follow regulations contained HUD 24CFR Termination of Assistance to Participants, sections C 582.320.)

- i. Instructions for requesting a review (appeal) of the decision will be provided in the written notice.
 - ii. The written notice will include a notification date.
- (b) The participant will have 10 business days from the notification date to request a review (appeal) following the instructions provided in the written notice.
- (c) Requested review (appeals) should be submitted to the Franklin County Supportive Housing Program 39 N. Second Street, Chambersburg, PA 17201.
- (d) A person, other than the person (or subordinate of that person) who made or approved the original termination decision, will conduct a review of the reasons for original termination and the written information and objections to the termination decision. A participant may request to provide information and objections orally.
- (e) This review will be held within 10 business days after receipt of the participant's review request. The date of this review will be noted in the final decision notification.
- (f) Written notice of the final decision following the due process review will be sent or provided to the participant no later than 10 business days from the date of the review.

Grievances:

All participants are granted recognition of their rights and due process in submitting a grievance, as follows:

- (1) A formal grievance should be made in either a written or oral format.
 - a. Grievances can be directed to a supervisor or department director for Community Connections.
- (2) A review of the grievance will be conducted within 10 business days after receipt.
- (3) Written notice of the final decision following the review will be sent or provided to the participant no later than 10 business days from the date of the review.

Appeals:

All participants are granted recognition of their rights to appeal a decision that has been made by the Community Connections Supportive Housing Program, as follows:

- (1) Participants will have 10 business days from the notification date to request a review (appeal) following the instructions provided in the written notice.
- (2) Requested review (appeals) should be submitted to the Franklin County Supportive Housing Program 39 N. Second Street, Chambersburg, PA 17201.
- (3) A person, other than the person (or subordinate of that person) who made or approved the original decision, will conduct a review of the reasons for the original decision and the written information and objections to the decision. A participant may request to provide information and objections orally.
- (4) This review will be held within 10 business days after receipt of the participant's review request. The date of this review will be noted in the final decision notification.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

- (5) Written notice of the final decision following the review will be sent or provided to the participant no later than 10 business days from the date of the review.

Displacement, Relocation, and Acquisition

Minimizing Displacement - FCSHP Leasing Program will take reasonable steps to ensure that displacements are minimized for you. In the event that you are displaced for reasons other than:

- (a) Eviction for serious or repeated violations of the terms and conditions of the lease with the landlord,
- (b) You are not displaced as a direct result of acquisition, rehabilitation, or demolition of the property, or
- (c) You are not displaced in order to evade the obligation to provide relocation assistance,

The FCSHP Leasing Program will provide relocation assistance to you and assist with finding suitable alternative housing that does not exceed either:

- (a) Your rent and estimated utility costs prior to the displacement, or
- (b) 30 percent of your gross adjusted monthly income

and will provide reasonable assistance with out-of-pocket expenses you may incur in order to move.

It is noted that FCSHP does not engage in acquisition or demolition of any of the properties, as they are independently owned, so the only reasons you might be displaced would be if you were evicted, if the rent was increased beyond the rent reasonableness standards set forth in HUD Regulation 578.75, or if an act of nature made the unit ineligible for assistance due to violating a condition of the habitability standards. If you are displaced due to serious violations of the lease agreement or through some other serious antecedent within your control, you will be automatically ineligible for relocation assistance.

In the event that you are displaced and disagrees with the FCSHP's determination of whether you are defined as a "displaced" individual or the amount of relocation assistance to which you are entitled, you may file a written grievance with the program. Additionally, if you are dissatisfied with the outcome of such an appeal, you may submit a written request for review to the local HUD office.

Transportation Assistance Policy

I understand through the Franklin County Supportive Housing Program that I am eligible to receive Persons with Disabilities transportation services at no cost to me. This service is paid for through the program while I am a tenant in the program.

I understand that rabbittransit will maintain records of the transportation services provided. Transportation allowed includes the following examples: employment, New Visions Clubhouse, grocery stores, and medical appointments (non-medical assistance reimbursed), social service agencies, social security office, etc. I will also abide by any applicable Persons with Disabilities transportation guidelines.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

Utility Deposit Assistance

I understand through the Franklin County Supportive Housing Program that I am eligible to receive assistance with the cost of a utility deposit at no cost to me. This assistance is provided to me through the program while I am a tenant in the program.

I understand that any security deposit paid on my behalf will be stay with the program and unit. Any unused utility deposit will be returned to the program, if I am to leave the program or the specific unit the deposit was paid for.

I agree that if I choose to have any of the following utilities: cable television, telephone, cell phone, or Internet usage, I will be solely responsible for these, as they are considered luxury items.

Emotional Support/Service Animal Policy

FCSHP Emotional Support/Service Animal Policy was established by following the federal Fair Housing Act (FHA), Section 504 of the Rehabilitation Act (RA) and the Pennsylvania Human Relations Act (PHRA). As identified per the FHA and RA service animals are defined as any type of animal that is needed by an individual with a disability to afford them equal opportunity to use and enjoy housing as long as there is a connection between the individual's disability and the service that the animal provides. Service animals in housing can include animals that perform specific tasks for the individual with a disability, such as guiding a person who has a visual disability; picking up or retrieving objects for a person with a physical disability; providing support for a person with a disability that affects his balance; alerting a person who is deaf to sounds; alerting persons to impending seizures; preventing a child with autism from wandering; and preventing detrimental behaviors by a person with post-traumatic stress disorder.

Aside from service animals that perform tasks, animals that provide emotional support for individuals with disabilities are also considered service animals under the FHA and RA's housing provisions.

You have the right to the use of an emotional support or service animal in your home and cannot be discriminated against for this reason. When needing the use of an emotional support or service animal, you are required to request a reasonable accommodation before placing a service animal in the home. This ensures that all requirements are being met such as proof of disability and the animal serves a function that is related to their disability, if it is requested by the landlord.

FCSHP has established an emotional support and service animal agreement that outlines the responsibilities which you will abide by. Discharge from the housing program or the need to remove an animal from the premises may be required if: they pose a "direct threat" to the health or safety of others that cannot be reduced or eliminated by a reasonable accommodation; animal is not properly vaccinated or licensed, per PA law; animal causes excessive damage; feces and/or urine is not properly cleaned up and/or disposed of both in residence and per borough ordinance; animal is not being properly cared for; etc.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

Consideration for discharge from FCSHP or the need to remove an animal from the premises will be assessed on a case-by case basis after evaluating all extenuating circumstances and determining only in the most severe cases that there are no other resolutions available.

SO WHAT IS NEXT STEPS FOR ME? YOUR JOURNEY BEGINS!!!

After reading this manual, we hope that you will ask any questions that you may have. Our program operates best when you feel you are heard and feel comfortable in knowing what is expected, how services are provided and that success can come, but will require for you to be present in achieving that success.

Here are some suggestions you can do to start your journey to housing stability and independence.

1. Schedule appointments with the case management staff.
2. Establish goals that you want to work towards.
3. Determine what type of long-term housing you wish to achieve in the future. Rental vs Ownership?
4. Decide on: "Do I need SSDI/SSI or can I gain employment?"
5. Create a list of resources you feel would help you in your housing.

To contact the office and staff, please call (717) 261-3811. The office is located at 39 N. Second Street, Chambersburg. We are open Monday – Friday, 8:30 AM to 4:30 PM. Walk-ins are welcome anytime.

FRANKLIN COUNTY COMMUNITY CONNECTIONS SUPPORTIVE HOUSING PROGRAM PARTICIPANT MANUAL

I acknowledge that I have received, reviewed, and/or read a copy of the following Franklin County Community Connections Supportive Housing Program Participant Manual and the following policies contained in the manual:

- *Termination of Assistance to Participants, Grievances and Appeals Policy*
- *Displacement, Relocation, And Acquisition*
- *Transportation Assistance Policy*
- *Utility Deposit Assistance*
- *Emotional Support/Service Animal Policy*

Print Full Name (Head of Household)

Signature (Head of Household)

Date

I acknowledge that as a participant in this program, the following requirements will be met by me:

- *Provide proof of disability within 45 days of my enrollment.*
- *Provide proof of homelessness within 45 days of your enrollment.*
- *Meet with FCSHP staff for case management.*

Failure to meet these requirements can result in termination of assistance from the program.

Print Full Name (Head of Household)

Signature (Head of Household)

Date

I acknowledge that any furniture purchased by the program will remain the property of the program and will not transfer with me when I exit the program. Failure to follow this will result in me paying for items removed.

Print Full Name (Head of Household)

Signature (Head of Household)

Date

Print Full Name (Staff Member)

Signature (Staff Signature)

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Pathfinders Permanent Supportive Housing (PSH) Program. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Pathfinders PSH is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in Pathfinders PSH are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Pathfinders PSH provides the following supportive services to help participants obtain and retain permanent housing:

- Ongoing case management, inclusive of completing all required assessments
- Development and monitoring of individualized service plans, ensuring goals are identified and worked on using a person-centered approach.
- Housing stability and tenancy support
- Wellness planning, coordination with, and referrals to, medical and behavioral health providers, assistance with medication coordination
- Substance use treatment referrals and recovery supports
- Assistance with crisis intervention
- Medical transportation coordination and assistance
- Appointment scheduling and follow-up
- Assistance obtaining benefits and income supports (SSI, SSDI, SNAP, Medicaid eligibility, Medicare enrollment, LIHEAP, other mainstream resources, etc.)
- Budgeting and money management

- Household management, assistance w/ meal planning, nutrition & grocery shopping
- Community integration and community resource linkages.
- Life skills development
- Employment assistance & vocational referrals
- Assistance with finding education and training
- Finding volunteer and other community opportunities

As a participant in Pathfinders PSH, I agree to:

- ☐ Meet or communicate with my assigned case manager at least bi-weekly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Pathfinders PSH service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, Pathfinders PSH may consider further action under its written

policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **PA0447 PSH Consolidated**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

PA0447 PSH Consolidated is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **PA0447 PSH Consolidated** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

PA0447 PSH Consolidated provides the following supportive services to help participants obtain and retain permanent housing:

Description of Supportive Services Offered to Participants

CCHRA Case Managers will provide individualized, housing-focused supportive services to assist households experiencing chronic homelessness and disability in obtaining and maintaining permanent housing. Services will be person-centered, trauma-informed, and tailored to each household's strengths, preferences, goals, abilities, and identified needs. The primary focus of supportive services will be to promote housing stability, successful tenancy, increased independence, and long-term retention of permanent housing.

CCHRA Case Managers will provide ongoing housing stabilization and case management services based on the individual needs of each household. Services may include assistance with identifying and maintaining appropriate housing, understanding lease terms and tenant responsibilities, communicating with landlords, addressing tenancy concerns, maintaining the unit, managing household responsibilities, and resolving issues that may place housing at risk. Case Managers will assist households in developing practical strategies to address barriers to housing stability and will provide intervention and problem-solving support when concerns arise.

Tenancy education and skill-building will be provided to support successful housing retention. Services may address rent obligations, utilities, budgeting, household management, property care, home maintenance, communication with landlords and neighbors, and understanding tenant rights and responsibilities. CCHRA Case Managers may utilize the Prepared Renters (PREP) curriculum and other appropriate educational resources to strengthen tenancy skills and promote long-term housing stability.

Supportive services will also address the impact of disability and other barriers that may affect a household's ability to maintain housing. Case Managers will assist households in identifying and accessing appropriate healthcare, behavioral health, substance use, disability-related, and other community-based services. With appropriate consent, Case Managers may coordinate with service providers and other community partners to facilitate continuity of care, address identified needs, and support housing stability.

CCHRA Case Managers will provide assistance with obtaining and maintaining identification, birth certificates, Social Security documentation, income verification, benefit documentation, and other records necessary to access housing, healthcare, public benefits, employment, and

community resources. Case Managers will assist households in accessing and maintaining mainstream benefits and other sources of income for which they may be eligible.

Financial stability services will include individualized assistance with budgeting, managing household expenses, planning for rent and utilities, addressing financial barriers, and developing strategies to maintain housing. Employment, education, and income-development services will be offered when appropriate and consistent with the household's goals, abilities, and preferences. Case Managers may assist households in accessing employment services, vocational rehabilitation, workforce development, educational opportunities, and other resources that may support increased financial stability.

CCHRA Case Managers will provide ongoing housing stabilization and problem-solving assistance when circumstances may place a household's housing at risk. Interventions may address landlord communication, lease-related concerns, rent or utility issues, changes in household circumstances, loss or reduction of income, property concerns, behavioral health or other service needs, and other identified barriers to housing stability. With appropriate consent, Case Managers may communicate and coordinate with landlords, property management, healthcare providers, service providers, and other community partners to identify solutions and prevent avoidable housing loss.

Services will be provided using a progressive engagement approach, with the type, frequency, and intensity of assistance adjusted according to each household's circumstances and changing needs. Support may include case management, education, advocacy, problem-solving, benefits assistance, resource coordination, mediation or communication support, and connection to community-based services. Services will be offered in a manner that promotes participant choice, autonomy, dignity, and self-determination.

CCHRA Case Managers will coordinate with Federal, State, County, nonprofit, healthcare, behavioral health, disability, and other community-based organizations to supplement services available through the PSH program. Referrals, warm handoffs, collaborative service planning, and ongoing coordination will be used as appropriate and with required participant consent.

Overall, supportive services will be designed to help households maintain permanent housing, strengthen tenancy skills, address barriers associated with homelessness and disability, increase access to income and mainstream resources, improve household stability, and support each household's ability to remain safely and successfully housed over time.

As a participant in **PA0447 PSH Consolidated**, I agree to:

- ☐ Maintain regular communication with my assigned case manager throughout my participation in the program. Communication will generally occur weekly during the initial enrollment period and may be adjusted thereafter based on my individual needs, goals, and progress. Communication may occur in person, by telephone, virtually, or through other mutually agreed-upon methods.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **PA0447 PSH Consolidated** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.



Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **PA0447 PSH Consolidated** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



Better Places, Better Lives

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **PA0812 Transitional Housing**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

PA0812 Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **PA0812 Transitional Housing** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

PA0812 Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

Description of Supportive Services Offered to Participants

CCHRA Case Managers will provide individualized, housing-focused supportive services to assist households in obtaining and maintaining permanent housing. Services will be tailored to each household's identified needs, strengths, goals, and barriers and will focus on addressing factors that may prevent a household from obtaining or maintaining stable housing.

CCHRA Case Managers will provide housing-focused case management and assistance with identifying and addressing barriers to housing stability. Services will include assistance with identifying appropriate housing, support in completing rental applications, obtaining required documentation, communicating with landlords, understanding leases, and understanding tenant rights and responsibilities. Case Managers will also provide education and practical assistance related to household management, property care, home maintenance, utilities, energy conservation, rent obligations, and landlord communication. CCHRA Case Managers will utilize the Prepared Renters (PREP) curriculum to provide structured tenancy education and strengthen skills needed for successful housing retention.

Financial stability services will include assistance with household budgeting, managing expenses, planning for rent and utilities, and addressing financial barriers. Case Managers will assist households with obtaining identification, birth certificates, Social Security documentation, income verification, and other documents needed for housing, employment, public benefits, or other services.

Employment and income development will be an important component of the project's housing stability strategy. CCHRA Case Managers will provide employment counseling and assist households in identifying employment, workforce development, job training, and educational opportunities. Case Managers will also help households access mainstream benefits and community resources based on identified needs, including healthcare, behavioral health, childcare, transportation, food, and other basic-needs resources.

CCHRA Case Managers will provide housing stabilization and problem-solving assistance when circumstances may place housing at risk. Services may address landlord communication, lease compliance, rent or utility concerns, changes in household circumstances, loss or reduction of income, and other barriers to housing stability. With appropriate consent, CCHRA Case Managers may coordinate with landlords, service providers, and other community partners to identify solutions and prevent avoidable housing loss.



CCHRA Case Managers will use a person-centered, trauma-informed, and progressive engagement approach. The type and intensity of supportive services will be responsive to household needs and may change as circumstances change. Services may include case management, education, advocacy, problem-solving, resource coordination, mediation communication with landlord and assistance accessing community-based services.

CCHRA Case Managers will coordinate with Federal, State, County, nonprofit, and community-based organizations to supplement services available through the program. Partnerships may include healthcare and behavioral health providers, employment and workforce development programs, public benefits agencies, childcare and transportation resources, food and basic-needs providers, and other mainstream and supportive service organizations. Referrals, warm handoffs, collaborative service planning, and ongoing coordination will be used as appropriate and with required participant consent.

Overall, supportive services will focus on helping households obtain permanent housing, establish and maintain successful tenancies, improve financial and household stability, increase access to income and community resources, and develop the skills and support necessary to remain housed and reduce the risk of returning to homelessness.

As a participant in **PA0812 Transitional Housing**, I agree to:

- ☐ Maintain regular communication with my assigned case manager throughout my participation in the program. Communication will generally occur weekly during the initial enrollment period and may be adjusted thereafter based on my individual needs, goals, and progress. Communication may occur in person, by telephone, virtually, or through other mutually agreed-upon methods.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **PA0812 Transitional Housing** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **PA0812 Transitional Housing** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



Weekly Service, Activity, and Employment Participation Requirement

Project(s): PA0384 HDC SHP 3 & PA0582 HDC SHP 6

This Addendum is incorporated into and made part of the participant's existing SHP Participation Agreement with the Housing Development Corporation of Northeastern Pennsylvania (HDC).

Weekly Participation Requirement

I understand that, in accordance with applicable U.S. Department of Housing and Urban Development (HUD) requirements and HDC's SHP program requirements, participants who are not exempt are required to complete at least twenty (20) hours per week of qualifying services, activities, and/or employment.

Qualifying participation may include: employment, case management, education or job training, employment-search activities, counseling or treatment, life-skills activities, volunteer or community service, work therapy, community-building activities, or other approved activities identified in my individualized service plan.

Exemptions

I understand that I am not subject to the 20-hour weekly participation requirement if HDC determines that I meet an applicable HUD exemption, including:

- ☐ Over 62 years of age
- ☐ An individual with a handicap as defined by 24 CFR § 8.3
- ☐ An individual with a developmental disability as defined by 24 CFR § 578.3
- ☐ Not currently exempt from the weekly participation requirement

Participant Acknowledgment

By signing below, I acknowledge that the 20-hour weekly participation requirement and applicable exemptions have been explained to me. If I am not exempt, I agree to complete at least 20 hours per week of qualifying services, activities, and/or employment and to notify my case manager of any barriers that may affect my participation.

I understand that failure to meet program participation requirements will be addressed in accordance with HUD requirements, HDC policies, and my existing SHP Participation Agreement.

Participant Signature: _____ **Date:** _____

HDC Staff Signature: _____ **Date:** _____



Permanent Supportive Program Agreement

Nittany House Apartments

This Program Agreement is made and entered into on _____ and will

Become effective on _____, between _____ and Housing Transitions.

Program and agreement background:

Housing Transitions is a non-profit organization dedicated to providing a continuum of well managed services to assist individuals and families find and maintain stable and affordable housing solutions. Services are provided in Centre County, and Nittany House Apartments are scattered site units leased by Housing Transitions.

Eligible program participants are experiencing chronic homelessness, by definition provided by Housing and Urban Development (HUD), and have a documented disability. The program is structured such that Housing Transitions holds the master lease with the landlord, and participants sign an occupancy agreement, agreeing to adhere to the requirements of the lease and this agreement with Housing Transitions. If the participant is meeting the requirements of the lease, occupancy agreement, and program agreement, the participant may remain enrolled in the Nittany House Apartments Program.

Responsibility of Housing Transitions:

- Pay rent to the landlord in a timely manner
- Serve as a liaison with the landlord of the property to address maintenance issues, as needed
- Provide monthly inspections of the unit
- Provide verbal and written feedback for participants
- Help set goals and provide case management to assist participants maintaining housing
- Regularly create and review an Individualized Service Plan with the participant

Responsibility of Participant

- Pay rent to Housing Transitions in the amount of 30% of adjusted gross monthly income
- Provide documentation of income certification. If employed, documentation of the income for the previous month is due on the 5th of the month. If you receive social security, an updated award letter must be provided each year, and any time there is a change.
- Provide accurate information related to income, disability and contact information.
- Agree to and adhere to the rules and regulations of the lease for the apartment, and sign the occupancy agreement.
- Maintain the apartment in good condition and remain in good standing with the landlord.

Supportive Services Engagement

Nittany House is funded through the US department of Housing and Urban Development. In alignment with federal regulations (24 CFR 578.75), participants in Nittany House Apartments are expected to engage in supportive services that will help maintain housing. Participant requirements are individualized and based on your strengths, needs, preferences, and the goals identified in your Individualized Service Plan (ISP)

As a result, in addition to the above responsibilities, you are also required to:

- Meet with the assigned case manager at least once every other week, but more frequently if required by the service plan.
- Meet at your apartment at least once monthly.
- Participate in service planning focused on maintaining housing, increasing financial independence, and connecting to needed supports.
- Work with your case manager to create, review, and update your Individualized Service Plan and Housing Stability Plan.
- Work with your case manager to pursue employment and/or benefits that will help support housing stability and self-sufficiency
- Tell program staff about major changes that may affect housing, income, household, health, safety or ability to participate in services.
- Notify program staff if you are unable to attend a scheduled meeting and find a new time to meet.

If you have a disability that makes it difficult to meet the Nittany House Apartments Program service participation requirements, you may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows you to participate in the program. Program staff will explain how to request accommodation and will work with you through the program's reasonable accommodation process.

If you stop participating in required services, staff will try to contact you to understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to your service plan, or other reasonable steps to help you reengage.

Failure to participate in services does not automatically result in termination from the program, or loss of housing assistance. If you continue not to participate after staff have made reasonable efforts to help you reengage, Nittany House Apartments may consider further action under its written policies. Further action may include a written warning, a corrective action plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. You will receive notice of any action that could affect participation and will have the opportunity to respond or appeal according to program policies.

ACKNOWLEDGEMENT

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

This agreement will automatically be renewed on the first of each month unless written amendments are presented and signed by all parties.

Any program participant who wishes to move and exit the program is requested to provide thirty (30) day notice.

Housing Transitions reserves the right to terminate any participant from the program for failure to comply with the requirements of the sublease and the rules and guidelines of the program. A written thirty (30) day notice will be provided to a participant who will be exited from the program. Immediate termination may occur in the event of dangerous or unlawful conduct by the participant.

Supportive Housing Case Manager: _____ Date: _____

Program Participant: _____ Date: _____

VSP Service Participation Agreement Template

For CoC-Funded Victim Service Provider (VSP) Projects – FY2026 NOFO

How to Use This Template

Victim Service Providers (VSPs) are bound by federal statutes and regulations, stating that survivors cannot be required to participate in services offered by VSPs. VSPs should select services offered that apply to this project, add any project-specific guidance for survivors, and remove sections that do not apply.

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Safe Haven Partnership**. As part of this program, you are encouraged to participate in the supportive services offered to help you maintain safe, stable housing and achieve your personal goals. This agreement explains the support services available to you as a participant enrolled in this program.

Safe Haven Partnership is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75), participants in **Safe Haven Partnership** are to be offered supportive services that will help you become safer and maintain housing stability. Participation is individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

Safe Haven Partnership provides the following supportive services to help participants obtain and retain permanent housing:

Every guest is offered assistance with all of the following:

- A community partner providing a comprehensive case management approach to support victims of sexual violence as they navigate the healing process
- Important documentation replacement
- Substance abuse recovery & relapse prevention services in-house and with Community partners
- Job search, job preparation, and skills building programming; assistance with child care resources
- Case management and advocacy
- Health/dental care in-house and with community partners
- personal financial budgeting including savings goals
- Parenting/life skills classes in-house and with community partners
- Trauma informed care that centers on empowerment and trust
- In-house and community partner resources for mental health, and spiritual health
- Housing application advocacy
- Legal/criminal/probation/fine restitution support services in-house and with community partners
- Needed transportation to accomplish the myriad of challenges that are faced while a guest is rebuilding their life after homelessness.

As a participant in **Safe Haven Partnership** I understand the services offered and the encouragement to engage in them. Such services are:

- ☐ Meeting or communicating with my assigned advocate/case manager to answer questions and provide general support for adjusting to a new environment.
- ☐ Working with my advocate/case manager on safety planning, maintaining housing, increasing independence, and connecting to needed supports.

- ☐ Partnering with program staff to create, review, and update my Individualized Service Plan, Housing Stability Plan, and safety plan.
- ☐ Working with my advocate/case manager to pursue employment and/or benefits that will help support my financial safety and stability, ability to maintain my housing, and increase my self-sufficiency.
- ☐ Talking with program staff about support I need regarding sobriety and whether sobriety needs to be a part of ongoing safety planning.
- ☐ Telling program staff about major changes that may affect my housing, income, household, health, safety, or ability to engage with services offered.
- ☐ Letting program staff know if I cannot attend a scheduled meeting and working with staff to reschedule.

If I have a disability that makes it difficult for me to engage in **Safe Haven Partnership** services, I may request a reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

If I stop engaging in services, staff will try to contact me and understand what is making engagement difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to engage in services will not result in termination from the program or loss of housing assistance. If I am unable to engage after staff have made reasonable efforts to help me re-engage, **Safe Haven Partnership** will work with me to either increase engagement or find a housing option that better meets my needs.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Conference's Pathways PSH program. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

The Conference's PSH program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in The Conference's Pathway PSH program are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

The Conference's Pathways PSH program provides the following supportive services to help participants obtain and retain permanent housing:

- Program participants are assisted to obtain and remain in permanent housing in a manner that fits their needs. Participants will work with their case managers to address their individual housing barriers. This includes, but is not limited to, income, health (mental and physical), benefits, life skills, fines, and debts. A participant will be offered all the services at the Conference, such as SOAR, employment/benefits navigator, safety planning, case management, life and coping skills, socialization, furniture, ICMs, meals, landlord navigator (housing search and placement), and transportation. The case manager will assist with benefit changes to obtain volunteer and/or work opportunities.

457 W Allen Street, Allentown, PA 18102
 Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





Wraparound services are provided to ensure retention of housing. The case managers will partner with Certified Peer and Recovery Specialists in our agency; these are trained specialists who use their lived experience with mental health or substance use challenges to support others in their recovery journey.

As a participant in The Conference's Pathways PSH program I agree to:

- ☐ Meet or communicate with my assigned case manager at least monthly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Conference's Pathways PSH program service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, Conference's Pathways PSH program may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to The Conferences Pathways TH Program. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

The Conferences Pathways TH Program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in The Conferences Pathways TH Program are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

The Conferences Pathways TH Program provides the following supportive services to help participants obtain and retain permanent housing:

457 W Allen Street, Allentown, PA 18102
 Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org



United Way of the
Greater Lehigh Valley



**Pathways Master Lease Program
HUD Participant Agreement**

As a participant in the Pathways HUD Master Lease Program, I, _____, the subtenant, agree to the following:

1. I will actively participate with Housing Case Manager by:
 - a. Providing all necessary and accurate information to complete eligibility and enrollment process to enter program.
 - b. Once enrolled, By reporting all changes in my current situation including but not limited to: income, household size, and services within 10 business days
 - c. Participating in the development of regular reviews of a self sufficiency plan
 - d. Actively working on identified goals as outlined in the self-sufficiency plan to increase self sufficiency and independence
 - e. Keeping scheduled appointments and contacting the Housing Case Manager on a weekly basis
2. I will not sign a lease or any agreements with Landlord or contractors without the Housing Case Manager's Approval
3. I will be required to contribute 30% of my income towards my rent: \$ _____ and forward payment directly to **The Lehigh Conference of Churches, Attention: HUD, 457 Allen Street, Allentown, PA 18102**, by the 1st of each month.
4. Working with The Housing Case Manager to make appropriate referrals to other agencies and service providers as necessary to achieve ongoing goals
5. I will be available for all scheduled home visits with Program Staff
6. I will follow all rules and regulations of the Master Lease, maintain housing in a safe and sanitary condition and will communicate with the Housing Case Manager of any unit or landlord/tenant issues
7. I will not allow others to reside with me without first receiving approval from the Housing Case Manager and Landlord
8. I understand that all information provided to the Housing Case Manager will be treated as confidential. I will be asked to sign a Release of Information/Consent Form in order to release any information regarding my housing support needs to another person or agency for the purpose of obtaining assistance for me
9. I may be terminated from the HUD Pathways Master Lease Program for any of the following:
 - a. Violence and/or threats toward staff or other residents
 - b. Possession and/or use of illegal use of drugs or Any illegal activities
 - c. Nonpayment of rent or utilities
 - d. Destruction of property
 - e. Physical incapacity to care for myself
 - f. Abandonment of unit and/or no communication with program
 - g. Any other Master Lease or Sublease violation

If I fail to meet, the responsibilities and requirements of this agreement it may result in my dismissal from the HUD Pathways Program.

I have read and had the agreement explained to me and agree to all terms and requirements,

Participant: _____ Date: _____

Housing Case Manager: _____ Date: _____



Program participants are assisted to obtain and remain in permanent housing in a manner that fits their needs. Participants will work with their case managers to address their individual housing barriers. This includes, but is not limited to, income, health (mental and physical), benefits, life skills, fines, and debts. A participant will be offered all the services at the Conference, such as SOAR, employment/benefits navigator, safety planning, case management, life and coping skills, socialization, furniture, ICMs, meals, landlord navigator (housing search and placement), and transportation. The case manager will assist with benefit changes to obtain volunteer and/or work opportunities.

Wraparound services are provided to ensure retention of housing. The case managers will partner with Certified Peer and Recovery Specialists in our agency; these are trained specialists who use their lived experience with mental health or substance use challenges to support others in their recovery journey.

As a participant in The Conferences Pathways TH Program I agree to:

- ☐ Meet or communicate with my assigned case manager at least monthly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet The Conferences Pathways TH Program service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, The Conferences Pathways TH Program may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Conference's PSH program. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

The Conference's PSH program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in The Conference's PSH program are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

The Conference's PSH program provides the following supportive services to help participants obtain and retain permanent housing:

- Program participants are assisted to obtain and remain in permanent housing in a manner that fits their needs. Participants will work with their case managers to address their individual housing barriers. This includes, but is not limited to, income, health (mental and physical), benefits, life skills, fines, and debts. A participant will be offered all the services at the Conference, such as SOAR, employment/benefits navigator, safety planning, case management, life and coping skills, socialization, furniture, ICMs, meals, landlord navigator (housing search and placement), and transportation. The case manager will assist with benefit changes to obtain volunteer and/or work opportunities.

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





Wraparound services are provided to ensure retention of housing. The case managers will partner with Certified Peer and Recovery Specialists in our agency; these are trained specialists who use their lived experience with mental health or substance use challenges to support others in their recovery journey.

As a participant in The Conference's PSH program I agree to:

- ☐ Meet or communicate with my assigned case manager at least monthly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Conference's PSH program service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org





Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, Conference's PSH program may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

457 W Allen Street, Allentown, PA 18102
Tel: 610.439.8653 Fax: 484.664.7322
info@lehighchurches.org www.lehighchurches.org



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Pocono Mountains Transitional Housing**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Pocono Mountains Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **Pocono Mountains Transitional Housing** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Pocono Mountains Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

- Individualized case management: Each participant works with a case manager to develop a housing stability plan with clear goals and meets with them regularly to track progress and address barriers.
- Housing search and placement: Staff help participants find affordable units, complete rental applications, prepare for landlord interviews, and understand lease terms.
- Landlord engagement: The program builds relationships with local landlords and serves as a point of contact to reduce concerns about renting to participants with limited rental history, poor credit, or past evictions.

- Budgeting and financial literacy: Participants learn to create and follow a budget, build savings, address debt, and improve their credit so they can afford and keep permanent housing.
- Employment and income support: Staff connect participants to job training, job search help, and local employers, and help eligible participants apply for mainstream benefits such as SSI/SSDI, SNAP, and Medicaid.
- Document recovery: Case managers help participants obtain vital documents like photo ID, Social Security cards, and birth certificates, which are often required for housing and employment.
- Life skills and tenancy education: Participants learn practical skills such as housekeeping, understanding tenant rights and responsibilities, communicating with landlords, and resolving conflicts with neighbors.
- Behavioral health and substance use referrals: Participants are connected to mental health counseling, substance use treatment, and recovery support that help them stay stable in housing.
- Health care connections: Staff help participants enroll in health insurance and establish care with a primary care provider.
- Transportation assistance
- Employment readiness: Participants receive help with resumes, job applications, interview preparation, and workplace expectations so they can compete for and keep jobs.

As a participant in Pocono Mountains Transitional Housing, I agree to:

- ☐ Meet or communicate with my assigned case manager at least twice monthly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.

☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Pocono Mountains Transitional Housing** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Pocono Mountains Transitional Housing** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **New Bethany's Transitional Housing**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

New Bethany's Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75(h)), participants in **New Bethany's Transitional Housing** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

New Bethany's Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

New Bethany's Transitional Housing works with clients to remove barriers to safe, stable, and permanent housing for low-income individuals and households by offering a continuum of services that start with talking with the household to determine their needs, preferences, and financial resources. Every household will develop a goal plan with their Case Manager that has goals related to achieving and maintaining housing stability and other objectives to help them build a sustainable future and independent lives.

NB also offers team-based case management, access to nutritious food, assistance obtaining mainstream benefits, life skills training, financial literacy, job search resources, connection to childcare, and referrals with a warm handoff to mental health and substance abuse treatment, and other community partners. NB has a Barrier Remediation Fund that can provide bus tickets/gas cards/ride share, work attire and equipment, document acquisition, and other resources necessary to remove obstacles to self-sufficiency.

MAJOR ACTIVITIES/MOVE THROUGH THE PROJECT:

As a participant in **New Bethany's Transitional Housing**, I agree to:

X Meet or communicate with my assigned case manager at least **weekly**.

X Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.

X Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.

X Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.

X Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

X Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

If I have a disability that makes it difficult for me to meet **New Bethany's Transitional Housing's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **New Bethany's Transitional Housing** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Independence Gardens. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Independence Gardens is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in Independence Gardens are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Independence Gardens provides the following supportive services to help participants obtain and retain permanent housing:

- Financial services, transportation, healthcare, mental health, physical health, case worker/caregiver, case management, social security assistance, VA contacts/assistance, meal delivery support, career/job searching/assistance, clothing.

As a participant in Independence Gardens, I agree to:

- ☐ Meet or communicate with my assigned case manager at least quarterly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.

☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Independence Gardens service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, Independence Gardens may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **the Pennsylvania Coalition Against Domestic Violence (PCADV)**. As part of this program, you are encouraged to participate in the supportive services offered to help you maintain safe, stable housing and achieve your personal goals. This agreement explains the support services available to you as a participant enrolled in this program.

PCADV is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75), participants in **PCADV** are to be offered supportive services that will help you become safer and maintain housing stability. Participation is individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

Project Enrollment:

_____ Eastern PA CoC DV TH

_____ Eastern PA CoC DV RRH

PCADV provides the following supportive services to help participants obtain and retain permanent housing:

Survivors will determine their own goals and priorities, and advocates will develop individualized housing stability and engagement plans that reflect each household's unique circumstances, interests, abilities, employment, and partner-provided activities. Housing advocates will maintain frequent contact with participants through regularly scheduled meetings, home visits, and ongoing communication to monitor progress toward goals, review weekly engagement, identify emerging needs, and adjust service plans as circumstances change. Advocates provide a range of direct services, including case management, safety planning, counseling, financial empowerment, legal advocacy, support groups, and medical accompaniment, allows staff to respond quickly to changing participant needs. Staff will also coordinate referrals to partner-provided healthcare, behavioral health and substance use treatment, education, job training, volunteering, community-building activities, workforce development, public benefits, transportation, and other community supports.

As a participant in **PCADV**, I understand the services offered and the encouragement to engage in them. Such services are:

- ☐ Meeting or communicating with my assigned advocate/case manager to answer questions and provide general support for adjusting to a new environment.
- ☐ Working with my advocate/case manager on safety planning, maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Partnering with program staff to create, review, and update my Individualized Service Plan, Housing Stability Plan, and safety plan.

- ☐ Working with my advocate/case manager to pursue employment and/or benefits that will help support my financial safety and stability, ability to maintain my housing, and increase my self-sufficiency.
- ☐ Talking with program staff about support I need regarding sobriety and whether sobriety needs to be a part of ongoing safety planning.
- ☐ Telling program staff about major changes that may affect my housing, income, household, health, safety, or ability to engage with services offered.
- ☐ Letting program staff know if I cannot attend a scheduled meeting and working with staff to reschedule.

For Transitional Housing Projects

- ☐ I will be offered at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ I will work with my advocate/case manager to create a schedule that works for me for regular check-ins. During these meetings, we will discuss safety planning and offer additional services.

If I have a disability that makes it difficult for me to engage in **PCADV** services, I may request a reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

If I stop engaging in services, staff will try to contact me and understand what is making engagement difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to engage in services will not result in termination from the program or loss of housing assistance. If I am unable to engage after staff have made reasonable efforts to help me re-engage, **PCADV** will work with me to either increase engagement or find a housing option that better meets my needs.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Perry County Veteran's Program. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in Perry County Veteran's SHP are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Perry County Veteran's SHP provides the following supportive services to help participants obtain and retain permanent housing:

The following services are available on a weekly basis

- Case Management

The following services are on an as needed basis:

- Intake Assessment

- Assistance with moving cost

- Employment Assistance and Job Training

- Housing Search and Counseling

Mental Health Counseling and Services

Substance Abuse Treatment Service

Transportation assistance

Food Assistance

As a participant in Perry County Veteran's SHP, I agree to:

☐ Meet or communicate with my assigned case manager at least Bi-Weekly

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Perry Housing Partnership's service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, Perry County Veteran's SHP may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Perry Housing Partnership. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program. Perry Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in Perry Transitional Housing are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Perry Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

- The following services are available on a weekly basis
 - Case Management (daily as required)
 - Outreach Service
 - Substance Abuse Treatment
 - Assessment of Service Needs
- The following services are on an as needed basis:
 - Intake Assessment
 - Assistance with moving cost
 - Employment Assistance and Job Training
 - Housing Search and Counseling
 - Mental Health Counseling and Services

- Substance Abuse Treatment Service
- Transportation assistance
- Food Assistance
- Education Services
- Child Care Assistance
- Life Skills Training
- Outpatient Health Services
- Utility Deposit Assistance

As a participant in Perry Transitional Housing, I agree to:

- ☐ Meet or communicate with my assigned case manager at least weekly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Perry Transitional Housing service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the

program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, Perry Transitional Housing may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Crossroads Bonus Expansion**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Crossroads Bonus Expansion is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **Crossroads Bonus Expansion** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Crossroads Bonus Expansion provides the following supportive services to help participants obtain and retain permanent housing:

- Housing Supportive Services
- Targeted Case Management
- Regular Check Ins
- Individual Supports
- Referrals
- Other Supportive Services as needed

As a participant in **Crossroads Bonus Expansion** I agree to:

X ☐ Meet or communicate with my assigned case manager at least **Once per week**

X☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.

X☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.

X☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.

X☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

X☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Crossroads Bonus Expansion** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Crossroads Bonus Expansion** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Bridge House**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Bridge House is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75(h)), participants in **Bridge House** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Goal Plan.

Bridge House provides the following supportive services to help participants obtain and retain permanent housing:

- ☐ intensive case management
- ☐ assistance applying for benefits
- ☐ help obtaining and maintaining employment
- ☐ support in finding permanent housing
- ☐ coordination with other service providers

As a participant in **Bridge House**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least weekly.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Goal Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.

☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Transitional Housing Projects

☐ Participate in at least 20 hours per week of approved engagement activities, such as employment, training, or education. If not participating in such activities for at least 20 hours per week, 5 hours of community service must be performed that month.

☐ Report weekly schedule that includes case management, treatment, counseling, employment, education, job training, volunteering, and update the plan if my schedule or needs change.

Substance Use Treatment

Bridge House is a treatment-focused program that requires participants to engage in substance use treatment, if prescribed. As a Substance Use Disorder participant in **Bridge House** I agree to:

☐ Participate in the treatment, recovery support, counseling, peer support, medication-assisted treatment, or other services identified in my plan.

☐ Attend scheduled substance use treatment appointments, recovery meetings, counseling sessions, or other treatment-related services listed in my service plan.

☐ Notify program staff if I am struggling to access or maintain my treatment schedule.

☐ Tell program staff as soon as possible if I relapse, return to use, or believe I may be at risk of relapse, so staff can help me update my service plan, connect with treatment or recovery supports, and address any safety or housing concerns.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Bridge House** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the **Daybreak Transitional Housing Program**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Daybreak Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **Daybreak Transitional Housing** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Daybreak Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

- **Case Management to discuss finances and budgeting, locate units for housing, and link you with other services to help support your well-being and housing stability.**
- **Leasing services to help you understand the expectations of your lease and set up access for payments and issues with your unit.**



- **Landlord mediation if you have concerns with your unit and/or your landlord.**
- **Financial assistance to help support your rental payments while we work to ensure you can pay rent on your own.**

As a participant in **Daybreak Transitional Housing**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **two times per week prior to locating housing, and then one time per week for housing stability.**
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Daybreak Transitional Housing's** service participation requirements, I may request reasonable accommodation. A reasonable



accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program’s reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Daybreak Transitional Housing** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the **Daybreak Transitional Housing Program**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Daybreak Transitional Housing is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **Daybreak Transitional Housing** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Daybreak Transitional Housing provides the following supportive services to help participants obtain and retain permanent housing:

- **Case Management to discuss finances and budgeting, locate units for housing, and link you with other services to help support your well-being and housing stability.**
- **Leasing services to help you understand the expectations of your lease and set up access for payments and issues with your unit.**



- **Landlord mediation if you have concerns with your unit and/or your landlord.**
- **Financial assistance to help support your rental payments while we work to ensure you can pay rent on your own.**

As a participant in **Daybreak Transitional Housing**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **two times per week prior to locating housing, and then one time per week for housing stability.**
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Daybreak Transitional Housing's** service participation requirements, I may request reasonable accommodation. A reasonable



accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program’s reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Daybreak Transitional Housing** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



Tableland Services, Inc.

Community Action Partnership for Somerset County

Voice: 814.445.9628

800.452.0148

Fax: 814.443.3690

www.tableland.org

535 E Main Street

Somerset, PA 15501

PA0705

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Tableland Services, Inc.'s Permanent Supportive Housing Program. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Tableland Services, Inc.'s Permanent Supportive Housing Program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in Tableland Services, Inc.'s Permanent Supportive Housing Program are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Tableland Services, Inc.'s Permanent Supportive Housing Program provides the following supportive services to help participants obtain and retain permanent housing:

As Somerset County's Community Action Agency, TSI will connect participants to on-site and partner services, including:

- TSI will help participants access SNAP, TANF, Medical Assistance, and LIHEAP through Department of Human Services resources and COMPASS
- SOAR SSI/SSDI
- Employment and training will be addressed through PA CareerLink Somerset County, including:
 - the one-stop co-working Access Point in TSI's main office
 - job search support, career counseling, training referrals, and paid work experience
 - TSI Opportunity Center connections to homeownership opportunities as income and stability grow
- utility assistance
- Weatherization
- Transportation
- early childhood education and family stabilization
- Life skills classes, including:
 - Prepared Renter Education Program (PREP)
 - Housing Meetings
 - Budgeting
 - Nutrition
- TSI will partner with Behavioral Health Services and Open Rhodes 2 Recovery to connect participants to counseling, crisis supports, medication-management referrals, peer recovery support, and recovery coaching
- Health referrals will include UPMC Western Behavioral Health at Twin Lakes, Highlands Health Clinic, HealthChoices, and other providers for primary, behavioral health, and chronic condition care
- Case managers will coordinate with homeless school liaisons for families with school-age children.

As a participant in Tableland Services, Inc.'s Permanent Supportive Housing Program, I agree to:

- ☐ Meet or communicate with my assigned case manager at least once a week.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Tableland Services, Inc.'s Permanent Supportive Housing Program** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Tableland Services, Inc.'s Permanent Supportive Housing Program** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



Tableland Services, Inc.

Community Action Partnership for Somerset County

Voice: 814.445.9628
800.452.0148
Fax: 814.443.3690

www.tableland.org

535 E Main Street
Somerset, PA 15501

PA0366

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Tableland Services, Inc.'s Transitional Housing Program. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Tableland Services, Inc.'s Transitional Housing Program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in Tableland Services, Inc.'s Transitional Housing Program are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Tableland Services, Inc.'s Transitional Housing Program provides the following supportive services to help participants obtain and retain permanent housing:

As Somerset County's Community Action Agency, TSI will connect participants to on-site and partner services, including:

- TSI will help participants access SNAP, TANF, Medical Assistance, and LIHEAP through Department of Human Services resources and COMPASS
- SOAR SSI/SSDI
- Employment and training will be addressed through PA CareerLink Somerset County, including:
 - the one-stop co-working Access Point in TSI's main office
 - job search support, career counseling, training referrals, and paid work experience
 - TSI Opportunity Center connections to homeownership opportunities as income and stability grow
- utility assistance
- Weatherization
- Transportation
- early childhood education and family stabilization
- Life skills classes, including:
 - Prepared Renter Education Program (PREP)
 - Housing Meetings
 - Budgeting
 - Nutrition
- TSI will partner with Behavioral Health Services and Open Rhodes 2 Recovery to connect participants to counseling, crisis supports, medication-management referrals, peer recovery support, and recovery coaching
- Health referrals will include UPMC Western Behavioral Health at Twin Lakes, Highlands Health Clinic, HealthChoices, and other providers for primary, behavioral health, and chronic condition care
- Case managers will coordinate with homeless school liaisons for families with school-age children.

As a participant in Tableland Services, Inc.'s Transitional Housing Program, I agree to:

- ☐ Meet or communicate with my assigned case manager at least once a week.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.
- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Tableland Services, Inc.'s Transitional Housing Program** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Tableland Services, Inc.'s Transitional Housing Program** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

Allentown Hospitality House

Allentown Hospitality House PSH: Case Management Agreement

Purpose:

This Supportive Service Agreement ensures that participants enrolled in The Salvation Army's Housing Program receive the services needed to stabilize, work toward self-sufficiency, and achieve lasting stability and independence.

Expectations of Supportive Services:

Participants receive supportive services based on their strengths, needs, preferences, and goals identified in their service plan, and are expected to attend scheduled activities.

All supportive services help a participant make progress toward their goals. These services are designed to be beneficial for participants, and the topics and needs of supportive services that are offered are assessed by:

- Case management meeting (Weekly, Bi-Weekly, or as scheduled)
- Creating and maintaining progression in an individualized service plan.
- Engaging in life skills, employment services, financial literacy, and other program activities.
- Participating in treatment services if applicable (mental health, substance use, recovery support groups)
- Attending medical, dental, and specialty appointments as needed
- Complying with program rules, safety policies, and housing standards.

Types of Supportive Services offered, but not limited to:

- One-on-one intensive case management
- Recovery support (Referrals to appropriate agencies)
- Therapeutic activities
- Life skills training (budgeting, cooking, parenting, tenant rights)

- Health coordination (primary care, dental, behavioral, specialty care)
- Mental health coordination
- Employment and job readiness
- Volunteer opportunities
- Financial literacy
- Savings program
- Tenant Rights

If the participant has a disability that makes it difficult to meet service participation requirements, the participant may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows the participant to engage in the program. Program staff will explain how to request accommodation and will work with the participant through the program's reasonable accommodation process.

Lack of Participation:

If the participant stops participating in required services, staff will try to contact the participant and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to the service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If the participant continues not to participate after staff have made reasonable efforts to help me re-engage, **Allentown Hospitality House PSH Program** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. Participant will

receive notice of any action that could affect participation and will have the opportunity to respond or appeal according to program policies.

Duration of Agreement:

Agreement remains in effect for the duration of your participation in the program. It will be reviewed and updated as part of your case management and service plan updates.

Acknowledgement:

Participants are responsible for following through on their supportive services goals and communicating with their case manager if there are any barriers or additional support needed. Participants are encouraged to communicate with their case manager concerning meeting times and appointments.

I, _____, want to engage in supportive services and will collaborate with the case manager to maintain this expectation. I understand that if any barriers do arise, I will meet with my case manager and plan our next steps. I understand that program participants who are over the age of 62, or who have a physical disability or developmental disability, may be exempt from supportive services goals. I understand this does not include substance abuse disorders.

By signing this consent, you authorize The Salvation Army to maintain an electronic case file on your behalf, and you agree to participate in the required case management agreement.

Participant Name: _____

Participant Signature: _____

Date: _____

Case Manager Name: _____

Case Manager Signature: _____

Date: _____

Carlisle PSH Project: Case Management Agreement

Purpose:

This Supportive Service Agreement ensures that participants enrolled in The Salvation Army's Housing Program receive the services needed to stabilize, work toward self-sufficiency, and achieve lasting stability and independence.

Expectations of Supportive Services:

Participants receive supportive services based on their strengths, needs, preferences, and goals identified in their service plan, and are expected to attend scheduled activities.

All supportive services help a participant make progress toward their goals. These services are designed to be beneficial for participants, and the topics and needs of supportive services that are offered are assessed by:

- Case management meeting (Weekly, Bi-Weekly, or as scheduled)
- Creating and maintaining progression in an individualized service plan.
- Engaging in life skills, employment services, financial literacy, and other program activities.
- Participating in treatment services if applicable (mental health, substance use, recovery support groups)
- Attending medical, dental, and specialty appointments as needed
- Complying with program rules, safety policies, and housing standards.

Types of Supportive Services offered, but not limited to:

- One-on-one intensive case management
- Recovery support (Referrals to appropriate agencies)
- Therapeutic activities
- Life skills training (budgeting, cooking, parenting, tenant rights)

- Health coordination (primary care, dental, behavioral, specialty care)
- Mental health coordination
- Employment and job readiness
- Volunteer opportunities
- Financial literacy
- Savings program
- Tenant Rights

If the participant has a disability that makes it difficult to meet service participation requirements, the participant may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows the participant to engage in the program. Program staff will explain how to request accommodation and will work with the participant through the program's reasonable accommodation process.

Lack of Participation:

If the participant stops participating in required services, staff will try to contact the participant and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to the service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If the participant continues not to participate after staff have made reasonable efforts to help me re-engage, **Carlisle PSH Project** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. Participant will receive notice of any

action that could affect participation and will have the opportunity to respond or appeal according to program policies.

Duration of Agreement:

Agreement remains in effect for the duration of your participation in the program. It will be reviewed and updated as part of your case management and service plan updates.

Acknowledgement:

Participants are responsible for following through on their supportive services goals and communicating with their case manager if there are any barriers or additional support needed. Participants are encouraged to communicate with their case manager concerning meeting times and appointments.

I, _____, want to engage in supportive services and will collaborate with the case manager to maintain this expectation. I understand that if any barriers do arise, I will meet with my case manager and plan our next steps. I understand that program participants who are over the age of 62, or who have a physical disability or developmental disability, may be exempt from supportive services goals. I understand this does not include substance abuse disorders.

By signing this consent, you authorize The Salvation Army to maintain an electronic case file on your behalf, and you agree to participate in the required case management agreement.

Participant Name: _____

Participant Signature: _____

Date: _____

Case Manager Name: _____

Case Manager Signature: _____

Date: _____

Supportive Services Agreement

This Supportive Services Agreement outlines the expectations, responsibilities, and service participation requirements for all individuals enrolled in the Transitional Housing Program, funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) program.

Participant Name: _____

Unit Address and Number: _____

Effective Date: _____

1. Purpose

The goal of this program is to support participants in achieving housing stability, self-sufficiency, and overall well-being through supportive services and case management. Participation in supportive services is a condition of program enrollment and continued housing assistance.

1) Purpose & Authority

This Agreement explains the supportive services offered and the participant obligations related to services while enrolled in [Project Name]. It is issued pursuant to program rules (including 24 CFR 578.75(h) regarding participant engagement in supportive services) and the requirements described in the FY2025 CoC NOFO.

2) Services Offered

The project will provide or coordinate the following housing-focused services to help participants obtain and retain permanent housing:

Core Housing Services (in-house or via partner MOUs):

- Housing Case Management: [weekly / biweekly / monthly] by [Title or Partner].
- Housing Navigation/Lease-Up: [cadence] by [Title/Partner].
- Benefits Access (SSI/SSDI, SNAP, Medicaid/Medicare, TANF): [cadence] by [Title/Partner].
- Employment & Income Supports (WIOA/Workforce): [cadence] by [Title/Partner].
- Tenancy Skills / Budgeting / Landlord Mediation: [cadence] by [Title/Partner].
- Transportation Supports (bus passes, accompaniment): [as needed / schedule] by [Title/Partner].

- Behavioral Health / SUD linkages (incl. MAT if applicable): [referral cadence / onsite days] via [FQHC/BH provider].

Accessibility, Safety, & Cultural Responsiveness: Services will be delivered with reasonable accommodations, language access, trauma-informed practices, and flexible scheduling (including field-based/onsite visits) to meet participant needs.

Attach or reference the internal Service Plan that lists individualized goals, visit frequency, and responsible staff.

3) Participant Engagement Requirement (24 CFR 578.75(h))

By signing this Agreement, the participant acknowledges the following:

Required Services (select the items that apply to this project):

- ☐ Attend Housing Case Management at least [frequency].
- ☐ Participate in Tenancy Skills/Budgeting as scheduled.
- ☐ Complete Benefits Screening/Applications (SSI/SSDI/SNAP/Medicaid) with staff assistance.
- ☐ Participate in Employment Navigation/Job Coaching (if job-seeking).
- ☐ Safety planning and coordination for appointments as needed.
- ☐ Other project-specific required services: [list].

Optional/Offered Services (not required): [List optional offerings, e.g., peer support groups, life-skills classes.]

Reasonable Accommodations: If a disability or other circumstance affects participation, the participant may request reasonable changes to service delivery or cadence. The project will engage in an interactive process to adjust the plan.

4) 20 Hours/Week of Individualized Services

- The project will ensure each TH participant is offered 20 hours per week of individualized supportive services consistent with the FY2026 NOFO.
- Proportional Reduction for Employment: If the participant is employed, weekly service hours will be reduced proportionally to reflect work hours.
- Exclusions: Participants who are 62+ or who have a physical or developmental disability (not including SUD alone) are excluded from the 20-hour calculation.

- Documentation: The project will document weekly offerings and participation (or exemptions) in case notes/service logs.

5) Communication, Scheduling, & Attendance

- The project will provide a written Service Schedule (days/times/locations or virtual options).
- The participant agrees to keep scheduled appointments or notify staff of conflicts to reschedule.
- Missed contacts will trigger supportive follow-up (calls, texts, field attempts) to re-engage.

6) Monitoring, Progress, & Supportive Responses

Staff will record service contacts and progress in HMIS (or a comparable database for VSPs) consistent with CoC policies.

If engagement lapses, the project will use supportive, non-punitive steps (problem-solving, adjusting cadence/format, accommodations).

Graduated Responses for Persistent Non-Engagement:

- 1) Re-engagement outreach and barrier-solving.
- 2) Case conference to modify the plan and offer accommodations.
- 3) Written notice with options to re-engage and appeal.
- 4) As a last resort and when required by program rules/lease/occupancy agreement, the project may take administrative steps consistent with rights, protections, and due process.

Note: For RRH/PSH, housing retention should remain the priority. Non-engagement in services should not automatically cause a lease violation; follow your lease/landlord and program rules.

7) Participant Rights, Grievances, & Safety

- Rights & Non-Discrimination: Services are provided without discrimination, consistent with Fair Housing and applicable civil-rights laws.
- Confidentiality & VAWA: Information is confidential; survivors may refuse to share VAWA-protected information. Releases are time-limited and revocable.
- Grievances/Appeals: Participants may file a grievance about services or staff conduct. The project will provide a written process and respond within [X] days.
- Safety: The participant and staff will follow safety practices (home-visit protocols, scheduling during daylight where appropriate, etc.).

8) Data Collection & HMIS/Comparable Database

- The participant consents to data entry in HMIS (or a comparable database for VSPs) per CoC policy, with signed releases as required.
- Data will be used to coordinate care, track outcomes, and meet reporting requirements.

9) Mainstream Resources & Coordination

The project will help participants apply for and maintain benefits and resources (e.g., SSI/SSDI, SNAP, Medicaid/Medicare, TANF, WIOA/Workforce), and will coordinate with FQHCs/BH providers, housing authorities/landlords, and other community partners to support housing stability.

10) No Waiver of Rights

Nothing in this Agreement waives any rights afforded to the participant under applicable law, lease/occupancy agreements, or program rules.

11) Acknowledgment & Signatures

By signing below, the participant and project representative acknowledge that they have read, understand, and agree to the terms of this Supportive Services Agreement. A copy will be provided to the participant.

Participant: _____ Date: ____/____/____

Project Staff (Name/Title): _____ Date: ____/____/____

Agency Contact (Phone/Email): [Insert]

Transitions of PA Supportive Services Engagement Agreement

Participant Name: _____

ETO #: _____

Welcome to Transitions of PA's Housing Program. This program provides individualized supportive services to help participants increase safety, address housing barriers, obtain or maintain safe and stable housing, and work toward survivor-defined goals.

The program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations, including 24 CFR 578.75, and federal requirements applicable to Victim Service Providers (VSPs), supportive services are offered and encouraged but are voluntary. Participation is individualized and based on my strengths, needs, preferences, safety considerations, and goals.

By signing below, you acknowledge understanding that Transitions of PA is a Victim Service Provider and although encouraged, you cannot be required to participate in supportive services as a condition of receiving services from this program. Further you may choose which services you want to use, may decline a service, and may later choose to participate in a service you previously declined.

Supportive Services Offered

As a participant in the Transitions of PA Transitional Housing Program, I understand that I may be offered the following services based on my needs, preferences, and goals:

- Meeting or communicating with my Housing Advocate for case management, information, problem-solving, and general support.
- Safety planning based on my individual circumstances and preferences.
- Housing assessment, housing search, housing navigation, and help identifying safe and appropriate housing options.
- Housing stability planning and development or review of an individualized service plan.
- Landlord communication, advocacy, mediation, and assistance understanding leases, tenant responsibilities, and housing-related concerns.
- Assistance applying for benefits, income support, employment, education, or other resources that may increase financial stability.
- Transportation assistance or coordination when available and appropriate to help me access housing, benefits, healthcare, legal services, employment, or other services identified in my plan.
- Referrals and connections to community resources, including healthcare, behavioral health, legal services, substance use disorder treatment, education, employment, childcare, and other supports I identify as helpful.
- Coordination with other providers, with my permission when required, to support my housing and safety goals.

Internal use only – Program Enrollment:

- ☐ PA0445 Transitions of PA Permanent Supportive Housing
- ☐ PA1139 Transitions of PA PSH for Snyder and Northumberland Counties
- ☐ PA0859 SUN Counties Transitional Housing for Survivors
- ☐ Transitions of PA RRH for Survivors (PCADV)
- ☐ Transitions of PA Regional Transitional Housing for Survivors
- ☐ Transitions of PA SSO for Survivors

Engagement in Services

- ☐ I understand that I am encouraged to communicate with my Housing Advocate and may work with my Housing Advocate to establish a schedule for check-ins that works for me.
- ☐ I understand that I may work with my Housing Advocate to create, review, and update an Individualized Service Plan, Housing Stability Plan, and safety plan.
- ☐ I understand that I may work with my Housing Advocate on housing, employment, income, benefits, education, healthcare, legal, or other goals that I identify.
- ☐ I understand that I may tell program staff about changes in my housing, household, income, health, or safety when I would like assistance addressing those changes.
- ☐ I understand that if I cannot attend a scheduled meeting, I am encouraged to contact program staff if I am able so that another time or meeting method can be offered.

Voluntary Participation

I understand that participation in supportive services is voluntary. Declining a service will not prevent me from receiving other services for which I am eligible, and declining a service now does not prevent me from requesting or accepting that service later.

If I stop engaging in services, Transitions staff may attempt to contact me to understand what is making engagement difficult. Staff may offer different meeting options or locations, additional support, referrals, changes to my service plan, reasonable accommodation, or other reasonable steps to help me re-engage.

Failure to engage in supportive services will not, by itself, result in termination from the program. Transitions will continue to offer services and opportunities for engagement consistent with program requirements and my eligibility.

Reasonable Accommodations

If I have a disability that makes it difficult for me to access or engage in the SSO Program's services, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through Transitions' reasonable accommodation process.

Participant Acknowledgment

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

I understand that supportive services are available to me, that my participation in those services is voluntary, and that services will be individualized based on my strengths, needs, preferences, safety considerations, and goals.

Participant Name: _____

Housing Advocate: _____

Participant Signature: _____

Advocate Signature: _____

Date: _____

Date: _____

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Valley Youth House Lehigh Valley TH for Families Program**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Valley Youth House Lehigh Valley TH for Families Program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **Valley Youth House Lehigh Valley TH for Families Program** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Valley Youth House Lehigh Valley TH for Families Program provides the following supportive services to help participants obtain and retain permanent housing:

MANDATORY PARTICIPATION REQUIREMENTS

I agree to actively participate in the following mandatory activities:

- 1. 20-Hour Weekly Service Mandate:** I understand that I am required to actively participate in 20 hours per week of supportive services. This mandate is a core requirement for continued program assistance.
- 2. Housing Stability Plan (HSP):** I will be an active co-creator and partner in developing and updating my individualized Housing Stability Plan (HSP) with my assigned staff.
- 3. Goal Setting:** I agree to actively set goals related to housing stability, increasing

employment income, education, life skills, and financial management.

4. Communication: I agree to communicate regularly with my assigned staff person and respond promptly to their communications as outlined in my plan. I must inform staff of circumstances creating barriers to participation, such as work or school schedules, so adjustments can be made.

5. Rehousing Efforts: I agree to fully collaborate with the program to secure permanent housing and develop long-term resource plans.

6. Reporting Changes: I agree to promptly report changes in income, employment status, household composition, or other necessary information as required by program or HUD policy.

Qualifying supportive services include, but are not limited to:

- **Employment and Education:** Valley Youth House healing-centered employment training, other approved job-readiness or career training at a community-based partner organization, employment counseling, work placement, basic skills training, high school retention/support, career clarification, preparation for post-secondary education or vocational training, apprenticeships, internships, and literacy classes.
- **Case Management and Planning:** Individualized case management, goal planning, housing counseling, housing search and placement services, and developing life skills.
- **Health and Recovery:** Substance use treatment and mental health counseling.
- **Financial Stability:** Budgeting or credit counseling, and activities required under Temporary Assistance for Needy Families (TANF).
- **Other Required Services:** Community service activities, or any other service necessary to ready me for work or promote self-sufficiency.

As a participant in **Valley Youth House Lehigh Valley TH for Families Program**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **weekly**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

For Transitional Housing Projects

- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Valley Youth House Lehigh Valley TH for Families Program's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Valley Youth House Lehigh Valley TH for Families Program** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Valley Youth House Lehigh Valley TH for Youth Program**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

Valley Youth House Lehigh Valley TH for Youth Program is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75 (h)), participants in **Valley Youth House Lehigh Valley TH for Youth Program** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

There are limitations on what services this program may require you to participate in. The federal regulations referenced above (24 CFR 578.75 (h)) state that this program may require you to take part in supportive services that are not disability-related as a condition of continued participation in the program. If you are a person with a disability, that means that this program may provide but cannot require you to participate in disability-related services to address a condition caused by the disability in order to stay enrolled in this program. These kinds of disability-related services may include, but are not limited to, mental health services, outpatient health services, and provision of medication. However, the federal regulations also state that if the program's purpose is to provide substance abuse treatment services, then the program may require you to participate in substance abuse treatment services in order to stay enrolled in the program.

Valley Youth House Lehigh Valley TH for Youth Program provides the following supportive services to help participants obtain and retain permanent housing:

MANDATORY PARTICIPATION REQUIREMENTS

I agree to actively participate in the following mandatory activities:

- 1. 20-Hour Weekly Service Mandate:** I understand that I am required to actively participate in 20 hours per week of supportive services. This mandate is a core requirement for continued program assistance.
- 2. Housing Stability Plan (HSP):** I will be an active co-creator and partner in developing and updating my individualized Housing Stability Plan (HSP) with my assigned staff.
- 3. Goal Setting:** I agree to actively set goals related to housing stability, increasing

employment income, education, life skills, and financial management.

4. Communication: I agree to communicate regularly with my assigned staff person and respond promptly to their communications as outlined in my plan. I must inform staff of circumstances creating barriers to participation, such as work or school schedules, so adjustments can be made.

5. Rehousing Efforts: I agree to fully collaborate with the program to secure permanent housing and develop long-term resource plans.

6. Reporting Changes: I agree to promptly report changes in income, employment status, household composition, or other necessary information as required by program or HUD policy.

Qualifying supportive services include, but are not limited to:

- **Employment and Education:** Valley Youth House healing-centered employment training, other approved job-readiness or career training at a community-based partner organization, employment counseling, work placement, basic skills training, high school retention/support, career clarification, preparation for post-secondary education or vocational training, apprenticeships, internships, and literacy classes.
- **Case Management and Planning:** Individualized case management, goal planning, housing counseling, housing search and placement services, and developing life skills.
- **Health and Recovery:** Substance use treatment and mental health counseling.
- **Financial Stability:** Budgeting or credit counseling, and activities required under Temporary Assistance for Needy Families (TANF).
- **Other Required Services:** Community service activities, or any other service necessary to ready me for work or promote self-sufficiency.

As a participant in **Valley Youth House Lehigh Valley TH for Youth Program**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **weekly**.
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

For Transitional Housing Projects [DELETE THIS SECTION IF YOUR PROJECT IS NOT TRANSITIONAL HOUSING]

- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Valley Youth House Lehigh Valley TH for Youth Program's** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

Lack of Participation

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **Valley Youth House Lehigh Valley TH for Youth Program** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date



SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **The Way Home Transitional Housing Program (TWH)**. As part of this program, you are required to participate in the supportive services offered to help you maintain safe, stable housing and achieve your goals for self-sufficiency. This agreement explains the support services available and expectations for you as a participant enrolled in this program.

TWH is funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program. In alignment with federal regulations (24 CFR 578.75(h)), participants in **TWH** are expected to engage in supportive services that will help you maintain your housing. Participation requirements are individualized and based on your strengths, needs, preferences, and goals identified in your Individualized Service Plan (ISP).

TWH provides the following supportive services to help you obtain and retain permanent housing:

- **Case Management**
- **Food Assistance**
- **Housing & Resource Navigation**
- **Life Skills**
- **Financial and Renter's Education**
- **Community Health Workers (based on eligibility)**
- **Certified Peer Specialists (based on eligibility)**
- **Certified Recovery Specialists (based on eligibility)**
- **Moving, transportation, and rental assistance (contingent on funding availability)**

Linkages with the following resources may also be made, based on your needs:

- **Childcare**
- **Education services**
- **Employment assistance and job training**
- **Legal services**
- **Physical and/or mental health care**
- **Substance abuse treatment services**

As a participant in **TWH**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **weekly for the initial 6 months; after that time, visits may be decreased to every other week.**
- ☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.
- ☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.
- ☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.
- ☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.
- ☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Service Engagement Agreement

- ☐ Participate in at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.
- ☐ Work with staff to create a weekly engagement plan that shows how I plan to meet the required hours and update the plan if my schedule or needs change.

Substance Abuse Treatment Agreement

TWH is a treatment-focused program that requires all participants to engage in substance use treatment. As a participant in **TWH** I agree to:

- ☐ Participate in the treatment, recovery support, counseling, peer support, medication-assisted treatment, or other services identified in my plan.
- ☐ Attend scheduled substance use treatment appointments, recovery meetings, counseling sessions, or other treatment-related services listed in my service plan.
- ☐ Notify program staff if I am struggling to access or maintain my treatment schedule.

☐ Tell program staff as soon as possible if I relapse, return to use, or believe I may be at risk of relapse, so staff can help me update my service plan, connect with treatment or recovery supports, and address any safety or housing concerns.

If I have a disability that makes it difficult for me to meet **TWH** service participation requirements, I may request reasonable accommodation. A reasonable accommodation may include a change in how services are provided, a different meeting format or location, help with communication, or another support that allows me to participate in the program. Program staff will explain how to request accommodation and will work with me through the program's reasonable accommodation process.

If I stop participating in required services, staff will try to contact me and understand what is making participation difficult. Staff may offer different meeting options, additional support, referrals, changes to my service plan, or other reasonable steps to help me re-engage.

Failure to participate in services does not automatically result in termination from the program or loss of housing assistance. If I continue not to participate after staff have made reasonable efforts to help me re-engage, **TWH** may consider further action under its written policies. Further action could include a written warning, a corrective plan, a review meeting, or, in serious or ongoing situations, possible termination from the program or housing assistance. I will receive notice of any action that could affect my participation and will have the opportunity to respond or appeal according to program policies.

By signing below, I acknowledge that this agreement was reviewed with me, that I had the opportunity to ask questions, and that I received or was offered a copy.

Participant Signature

Date

Program Staff Signature

Date

FY 2026

PA-509 Eastern Pennsylvania

Continuum of Care

1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety

Documents include the following:

- **Memorandum of Understanding (MOU) between Valley Youth House (VYH) and The City of Allentown establishes a formal partnership to coordinate services, outreach, and referrals for homeless and at-risk youth in Allentown, Pennsylvania.**

Memorandum of Understanding (MOU)

Between Valley Youth House (VYH) and The City of Allentown (CITY)

I. Purpose

This Memorandum of Understanding (MOU) establishes a formal partnership between Valley Youth House (VYH) and the City of Allentown (CITY) to coordinate services, outreach, and referrals for homeless and at-risk youth in Allentown, Pennsylvania. The purpose is to enhance public safety, support vulnerable populations, and streamline referrals to appropriate services.

II. ROLES AND RESPONSIBILITIES

Valley Youth House (VYH) shall:

- Provide crisis intervention, housing navigation, case management, and referral services to homeless youth.
- Deploy trained outreach staff in targeted areas to engage youth in need.
- Maintain records of outreach and referral outcomes, in compliance with privacy laws.
- Provide training opportunities for Allentown Police Department officers to enhance their knowledge on trauma-informed and youth-centered approaches.

Allentown Police Department (APD) shall:

- When appropriate, identify and engage with homeless youth during patrols or public encounters.
- When appropriate, refer homeless youth to VYH using mutually agreed-upon referral protocols.
- When appropriate, participate in joint outreach and support efforts to build trust with youth.

III. COMMUNICATION PROTOCOLS AND POINTS OF CONTACT

- Each party shall designate a liaison to serve as the primary point of contact.

- VYH and APD liaisons shall meet as needed to review outcomes, share updates, and resolve operational challenges.
- In urgent situations, and when a referral is deemed appropriate by APD, on-call communication protocols shall be used to refer youth to VYH staff.
- Secure communication methods (email or phone) shall be used to protect client confidentiality.
- VYH shall comply with all requirements of 34 U.S. Code § 11275.

IV. Referral Procedures

- APD, if appropriate, shall notify VYH upon encountering unaccompanied or homeless youth.
- A notification call shall be used to ensure timely, consistent handoffs.
- VYH shall respond to referrals from APD by the next business day and shall provide status updates to APD when appropriate.
- Both parties shall track referral outcomes for reporting and program improvement.

V. Joint Outreach Strategies

- When appropriate, VYH and APD shall coordinate outreach.
- VYH may request police assistance if needed for outreach. If APD determines that police assistance is necessary and available, APD may provide support to ensure safety and peaceful engagement.
- VYH and APD shall report any suspected abuse to all required authorities as required by Local, State and Federal law.

VI. Safety Protocols

- VYH Outreach staff shall receive training in safety procedures when engaging youth in public areas.
- APD officers may, upon request from VYH staff, accompany VTH during outreach. APD shall determine if the requested assistance is feasible or necessary.

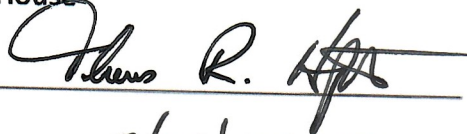
VII. Term and Review

- This MOU shall remain in effect for a period of one year from the date of signing, with automatic renewal unless modified or terminated by either party.
- This MOU may be terminated by either party upon written notice within seven (7) days prior to the date of termination.
- The MOU may be amended at any time upon mutual agreement in writing.

VIII. Signatures

For Valley Youth House

Signature:



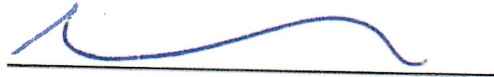
Date:



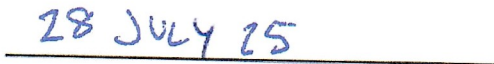
Thomas Harrington
President and Executive Director

For City of Allentown

Signature:



Date:



Matthew Tuerk
Mayor, City of Allentown

FY 2026

PA-509 Eastern Pennsylvania

Continuum of Care

1D-1. Local Competition Scoring Tool

Documents include the following:

- **Summary of renewal project scoring criteria meeting rating factor thresholds**
- **Eastern PA CoC: 2026 Renewal Project Scoring Criteria**
- **Summary of renewal project scoring criteria meeting rating factor thresholds**
- **Eastern PA CoC: FY26 New Project Proposal Scoring**

RENEWAL PROJECT LOCAL COMPETITION SCORING TOOL

Below please find outlined which criteria meet HUD requirements as outlined in the NOFO. The full renewal project scoring criteria document can be found on the following pages:

- See renewal project scoring criteria document for the maximum points for each of the following:
 - maximum points available for each project,
 - maximum points available for objective criteria to review, rate, and rank project applications,
 - maximum points available for system performance measures to review, rate, and rank project applications; and
 - maximum points available based on returns to homelessness performance, employment income performance, and supportive services participation requirements.
- Objective criteria were used and accounted for 100% of the criteria and related points included in the renewal project scoring tool for PSH, RRH, TH, TH/RRH, and SSO projects.
- System performance measures were used and accounted for at least 25% of the total points available. **The following renewal project criteria are related to system performance. System performance criteria for PSH, TH, RRH, TH/RRH make up 19 out of 63.5 points (29.9%) and SSO made up 16 out of 58.5 points (27.4%) for renewal project scoring.**

Criteria #	Criteria	Max Points: PSH	Max Points: RRH	Max Points: TH	Max Points: TH/RRH	Max Points: SSO
1	Housing Stability	10	10	10	10	10
2	Returns to Homelessness	2	2	2	2	0
4	Length of Time Between Project Start Date and Housing Move-In Date	1	1	1	1	0
5	Income Growth: Increase in Total	5	5	5	5	5
6	Employment Income Growth	1	1	1	1	1

- For housing projects (PH-PSH, PH-RRH, TH, Joint TH/PH-RRH), measures were considered for: returns to homelessness; employment income; and supportive service participation requirements. **The following renewal project scoring criteria were related to those areas:**

Criteria #	Criteria	Max Points: PSH	Max Points: RRH	Max Points: TH	Max Points: TH/RRH	Max Points: SSO
2	Returns to Homelessness	2	2	2	2	0
6	Employment Income Growth	1	1	1	1	1
20	Service Participation Requirement	1	1	1	1	0

Eastern PA CoC: 2026 Renewal Project Scoring Criteria

Approved by Funding Committee: 2/23/26

- Updated 6/18/26. Minor updates shown in red.

The time period used for all data will be October 1, 2024 – September 30, 2025

#	Criteria	Data Source	Point Structure
Performance and Data Quality= 41.5 points (RRH, TH-RRH, PSH); 38.5 points (SSO)			
1a	RRH/TH-RRH -Housing Stability: Exit to Permanent Housing (RRH and TH-RRH only). Non-DV/Non-Youth Dedicated Projects: <u>RRH Measurement:</u> % of exits to permanent housing destination among all participants/leavers who exited project. TH-RRH Measurement: % of exits to permanent housing destination or transitional housing among all participants/leavers who exited the project. DV Survivor or Youth- Dedicated Projects: <u>RRH/TH-RRH Measurement:</u> % of exits to permanent housing destination or temporary housing destination among all participants/leavers who exited project. <i>*NOTE: Funding Committee is implementing an alternative calculation for housing stability criteria for DV-dedicated and youth-dedicated projects, which includes exits to temporary housing as a positive exit. This is due to the unique nature of serving these specific target populations. The Funding Committee will evaluate the effectiveness of this alternate calculation to determine if this change will be retained in future years.</i> ----- <u>Note:</u> Individuals who exit to any of the below listed “destinations” will be removed from the calculation and therefore will not count negatively towards this outcome: • Hospital or other residential non-psychiatric medical facility • Foster care home or foster care group home • Long-term care facility or nursing home • Deceased • Jail, prison, or juvenile detention facility • Average outcome in 2025 = 81%	APR pulled from HMIS; APR from DV providers	<u>RRH and TH-RRH:</u> • 95% = 10 points • 85-94% = 7 points • 75-84% = 4 points • 70-74% = 2 points

#	Criteria	Data Source	Point Structure
1b	SSO-Housing Stability: % of all participants/leavers placed into Emergency Shelter, Transitional Housing or Permanent Housing (SSO only) <u>Note:</u> Individuals who exit to any of the below listed “destinations” will be removed from the calculation and therefore will not count negatively towards this outcome: • Hospital or other residential non-psychiatric medical facility • Foster care home or foster care group home • Long-term care facility or nursing home • Deceased • Jail, prison, or juvenile detention facility • Average outcome in 2025 = N/A (only 1 SSO project)	APR pulled from HMIS; APR from DV providers	SSO: • 75-100% = 10 points • 50-74% = 7 points • 36-49% = 4 points • 25-35% = 2 points
1c	PSH-Housing Stability: Exit to other Permanent Housing or retention of PSH (PSH only). Non-DV/Non-Youth Dedicated Projects: % of all project participants stayers remained in PSH project or all project participants/leavers exited to other permanent housing. DV Survivor or Youth- Dedicated Projects: % of all project participants stayers remained in PSH project or all project participants/leavers exited to other permanent housing or temporary housing. <i>*NOTE: Funding Committee is implementing an alternative calculation for housing stability criteria for DV-dedicated and youth-dedicated projects, which includes exits to temporary housing as a positive exit. This is due to the unique nature of serving these specific target populations. The Funding Committee will evaluate the effectiveness of this alternate calculation to determine if this change will be retained in future years.</i> ----- <u>Note:</u> Individuals who exit to any of the below listed “destinations” will be removed from the calculation and therefore will not count negatively towards this outcome: • Hospital or other residential non-psychiatric medical facility • Foster care home or foster care group home • Long-term care facility or nursing home • Deceased • Jail, prison, or juvenile detention facility • Average outcome in 2025 = 98%	APR pulled from HMIS; APR from DV providers	• 100% = 10 points • 97-99% = 7 points • 93-96% = 4 points • 90-92% = 2 points

#	Criteria	Data Source	Point Structure
2	Returns to Homelessness: % returns to homelessness within 6 months of exit to permanent housing destination ● Note: N/A for DV providers, as there is no way to measure if clients reentered the system, only their specific program. ● N/A for SSO Projects ● Average outcome in 2025 = 0.5%	HMIS	<u>PH projects:</u> ● ≤ 2% = 2 points ● 3-10% = 1 point
3	DV-Dedicated Projects Quarterly Monitoring DV-dedicated projects will be evaluated on participation in quarterly monitoring process (submitting requested APR data on time). In order to receive points, data must be received no later than 1 business day after the stated deadline. Anticipated scoring: ● 2 points total ● 0.5 points per quarter (2 points total for 4 quarters). In order to receive points, data must be received no later than 1 business day after the stated deadline.	Quarterly Monitoring submission records	Began evaluating in Q2 2025 2 points maximum Q1 2025: 0.5 points (all projects will receive points) Q2 2025: 0.5 points Q3 2025: 0.5 points Q4 2025: 0.5 points
4	Length of time between Project Start Date and Housing Move-in Date: % of households who moved into housing in under 60 days (measured by days between project enrollment date and move in date). (TH-RRH, RRH, and PSH Only) *N/A for SSO ● Average outcome in 2025: ○ PSH – 95% ○ RRH/TH-RRH – 84% Providers are expected to move participants in as quickly as possible upon enrollment; Decreasing length of time between project start date and housing move-in date is one factor that contributes to SPM Metric 1b (length of time homeless)	APR pulled from HMIS; APR from DV providers	● PSH: 90%+ moved into housing within 60 days of project enrollment = 1 point ● RRH: 80%+ moved into housing within 60 days of project enrollment = 1 point

#	Criteria	Data Source	Point Structure
5	Income Growth: Increase in TOTAL income of all adult participants from any source (leavers and stayers): % of all adult participants who increased income from any source from entry to exit/annual assessment (leavers and stayers) NOTE: Adult participants' Earned Income Growth and Non-Earned Income Growth both factor into Total Income Growth. - Average outcome in 2025: - PSH – 59% - RRH/TH-RRH - 30%	APR pulled from HMIS; APR from DV providers	PSH: 50% or more had an increase in total income = 5 points 40-49% increase income = 4 pts 30-39% increase income = 3 pts 20-29% increase income = 2 pts RRH/TH-RRH/SSO: 40% or more had an increase in total income = 5 points 30-39% increase income = 4 pts 20-29% increase income = 3 pts 10-19% increase income = 2 pts
6	Employment Income Growth: Increase in employment income of all adult participants from any source (leavers and stayers): % of all adult participants who increased employment income from entry to exit/annual assessment (leavers and stayers) Average outcome in 2025: 16%	APR pulled from HMIS; APR from DV providers	20%+ = 1 point 10-19%+ = 0.5 point
7	Participants with any income: % of adult participants with 1+ source of income at exit/annual assessment (leavers and stayers) Average outcome in 2025 = 64%	APR pulled from HMIS; APR from DV providers	60%+ - 5 points 50-59% - 4 points 40-49% - 3 points 30-39% - 2 points 20-29% - 1 point
8	Participants connected to Non-cash/ Mainstream Benefits: Percentage of adult participants with 1+ source of Non-Cash benefits (SNAP, WIC, TANF, others, etc.) Average outcome in 2025 = 65%	APR pulled from HMIS; APR from DV providers	70%+ of program participants enrolled in 1+ mainstream benefit = 3 points 60-69% = 2.5 points 50-59% = 2 points 40-49% = 1.5 points 30-39% = 1 point
9	Participants Connected to Health Insurance: Percentage of all participants with 1+ source of health insurance Average outcome in 2025 = 83%	APR pulled from HMIS; APR from DV providers	95%+ with 1+ source of health insurance = 3 points 80-94% = 2 points 70-79% = 1 point

#	Criteria	Data Source	Point Structure
10	High quality data entry: Full participation in HMIS is required of all CoC-funded organizations. % of Error Rate for the following data points entered into HMIS: a. PII - Name b. PII - Date of birth c. PII – Race/Ethnicity d. Destination e. Income and Sources at Entry f. Income and Sources at Annual Assessment g. Income and Sources at Exit	APR pulled from HMIS; APR from DV providers	7.5 points total ● 9.a. – 0% error rate – 0.5 points ● 9.b. – 0% error rate – 0.5 points ● 9.c.– 0% error rate – 0.5 points ● 9.d. – 0% error rate – 1.5 points ● 9.e.– 0% error rate – 1.5 points ● 9.f.– 0% error rate –1.5 points ● 9.g.– 0% error rate - 1.5 points
11	Timeliness of Data Entry a. % of project entry records entered into HMIS (or DV comparable database) within specified benchmark b. % of project exit records entered into HMIS (or DV comparable database) within specified benchmark Data entered within 10 days. Timeliness specifically looks at project entry and exit dates. For example, this measure will compare a household’s actual enrollment date against the date that their enrollment date was entered in HMIS. Per the HMIS Participation Agreement, all data should be entered into PA-HMIS within 7 days. ● Average outcome in 2025 – Entries = 70% ● Average outcome in 2025 – Exits = 65%	APR pulled from HMIS; APR from DV providers	4 points total a. Timeliness of Project Entries ● 90% - 2 points ● 85-89% - 1.5 points ● 80-84% - 1 point ● 75-79% - 0.5 Points b. Timeliness of Project Exits ● 90% - 2 points ● 85-89% - 1.5 points ● 80-84% - 1 point ● 75-79% - 0.5 Points
Grant Management/Monitoring = 12 points (TH-RRH, RRH, PSH); 10 points (SSO)			
12	Project Participant Eligibility: % of heads of household (entering the project during the lookback period) whose prior living situation was reported as literally homeless situations or fleeing DV Prior residence of heads of household served during the reporting period = Category 1 (literally homeless) or Category 4 (fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-	APR validation file (HMIS-participating projects) and RSF data	● 100%+ = 2 points ● 94-99% = 1 point

#	Criteria	Data Source	Point Structure
	threatening conditions that relate to violence against the individual or family member)		
13	Unit Utilization Rate: Average utilization rate of project (using project utilization each quarter, as reported on APR). Goal=full utilization. • N/A for SSO • For projects under 10 units, will use a 3-year average if the project is under 85% utilization.	# units per renewal app compared to average unit utilization; APR pulled from HMIS; APR from DV providers	• 95-100% utilization = 2 points • 90-94% = 1.5 points • 85-89% = 1 point
14	Funds Expended: % of grant funds expended. • Goal = full spend down	e-LOCCS and/or Sage data	• 100% = 5 points • 95-99% = 4 points • 90-94% = 3 points
15	Timely APR submission: APR submitted within 90 days of grant (HUD requirement)	Last submitted APR (Sage)	• Timely submission = 3 points • Submitted beyond 90 days = 0 points
CoC Participation and Priorities = 10 Points (TH-RRH, RRH, PSH); 10 points (SSO)			
16	RHAB Participation and CoC Leadership: Participation in RHAB meetings • <u>RHAB Participation:</u> Full participation in RHAB is expected in order to further the goals of the CoC. If program serves more than 1 RHAB, expectation that recipient OR subrecipients attend 75% or more RHAB meetings in all RHABs they serve in order to receive full points on this criterion (grantee will need to provide names of all their subrecipients) ▪ Grantees will be asked to provide list of all subrecipients as part of Renewal Summary Form	RHAB Chair, CoC Staff; Renewal Summary Form	2 points total • 75%+ RHAB meetings attended = 2 points • 50%+ RHAB meetings attended = 1 points • Less than 50% RHAB meetings attended = 0 points
17	CoC Meeting Attendance: Full participation in CoC is expected in order to further the goals of the CoC. ▪ For projects with multiple subrecipients, expectation is that, at a minimum, recipient attend CoC meetings and required trainings and ensure that information is disseminated to all subrecipients. Subrecipients are strongly encouraged to attend. ▪ For projects with one subrecipient, either recipient or subrecipient may attend.	CoC registration/attendance sheets; Renewal Summary Form	4 points total • 2 points awarded for attending October 2024 CoC meeting • 2 points awarded for attending April 2025 CoC meeting.

#	Criteria	Data Source	Point Structure
	- Grantees will be asked to provide list of all subrecipients as part of Renewal Summary Form - Grantees are strongly encouraged to attend trainings live. However, watching recorded trainings does count toward attendance. Attendee MUST submit an attendance survey to document that they watched the training.		
18	CoC Webinars and Trainings: Full participation/attendance in webinar and training opportunities is expected of all CoC funded organizations - For projects with multiple subrecipients, expectation is that, at a minimum, recipient attend CoC meetings and required trainings and ensure that information is disseminated to all subrecipients. Subrecipients are strongly encouraged to attend. - For projects with one subrecipient, either recipient or subrecipient may attend. - Grantees will be asked to provide list of all subrecipients as part of Renewal Summary Form - Grantees are strongly encouraged to attend trainings live. However, watching recorded trainings does count toward attendance. Attendee MUST submit an attendance survey to document that they watched the training.	CoC training attendance records	Attendance at CoC training events is expected of organizations receiving CoC funding. Maximum – 3 points Required trainings: - Fair Housing Training – 5/12/25 webinar – 0.5 points - Best Practices in Housing Retention – 4/22/25 or 4/23/25 or 5/7/25 or 5/8/25 (1 day in person) – 2 points - Mainstream Benefits Training – 5/19/25 webinar – 0.5 points
19 Not Scored in 2026	Coordinated Entry Participation - Participation in By Name List calls - Record Referral Outcomes for All HMIS Referrals (Excluding Victim Service Providers) - N/A for SSO projects 100% of Project Enrollments Referred Through CE (For Victim Service Providers this will be self-report) - N/A for SSO projects In future years, the CoC also plans to evaluate grantees on not rejecting/screening participants out for non-eligible reasons (once a policy is established related to this).	PA HMIS data and data from CE Managers	- BNL Call Participation – 75%+ attendance at BNL Calls– ~~0.5 point~~ 100% of Project Enrollments Referred through CE – ~~1 point~~ 100% Referral outcomes logged in HMIS – ~~0.5 point~~ Not Scored in 2026

#	Criteria	Data Source	Point Structure
20	Service Participation Requirement: CoC grantee requires participation in services in alignment with CoC and HUD requirements, except where prohibited by federal law.	CoC monitoring records	~~1 point 18 points~~ for submission of service participation requirement.
21	Late Submission (Penalty) if required CoC Renewal Scoring Documents are submitted after deadline (unless provided an extension due to extenuating circumstances) If a grantee needs to request a submission extension due to extenuating circumstances, this must be requested via email (to CoC email address) at least 2 business days in advance of deadline. Extensions will be reviewed and approved by the Funding Committee Chair. No extensions will be provided for submissions greater than 5 days after the stated deadline. Grantees are strongly encouraged to work ahead of the deadline to avoid the need to request an extension.	Review of Survey Submission Date	-2 point penalty for late submission of documents (late submission = any submission after the specific time/date of stated deadline) <i>No renewal scoring documents will be accepted later than 5 days after the stated deadline.</i>

Total Point Scale*:

- PSH/RRH/TH-RRH = 63.5
- SSO = 58.5

*NOTE: the total percentage of points awarded to each project will be converted to a 100-point scale so that project scores can be compared

APPENDIX: Data Calculations Explanation for HMIS/APR Related Scoring Criteria

Criterion #	Criterion	Calculation
1a	RRH/TH-RRH- HOUSING STABILITY/EXIT TO PERMANENT HOUSING: % of exits to permanent housing destination among all participants/leavers who exited project.	Non-DV/Non-Youth Dedicated Projects RRH APR Q23c: Exit Destination <u>Numerator:</u> (Q23c-Total persons exiting to positive housing destinations) <u>Denominator:</u> (Q23c-Total persons) - (Q23c- Total persons whose destinations excluded them from the calculation) - (Q23c Jail, prison, or juvenile detention facility) – (Q23c Client Doesn’t Know/Client Refused) TH-RRH APR Q23c: Exit Destination <u>Numerator:</u> (Q23c-Total persons exiting to positive housing destinations) + (Q23c -Transitional housing for homeless persons (including homeless youth)) <u>Denominator:</u> (Q23c-Total persons) - (Q23c- Total persons whose destinations excluded them from the calculation) - (Q23c Jail, prison, or juvenile detention facility) – (Q23c Client Doesn’t Know/Client Refused) DV/ Youth Dedicated Projects RRH or TH-RRH Projects APR Q23c: Exit Destination <u>Numerator:</u> (Q23c-Total persons exiting to positive housing destinations) + (Q23c- Total persons exiting to temporary housing destinations) <u>Denominator:</u> (Q23c-Total persons) - (Q23c- Total persons whose destinations excluded them from the calculation) - (Q23c Jail, prison, or juvenile detention facility) – (Q23c Client Doesn’t Know/Client Refused) ----- <u>Note:</u> Individuals who exit to any of the below listed “destinations” will be removed from the calculation and therefore will not count negatively towards this outcome: • Hospital or other residential non-psychiatric medical facility • Foster care home or foster care group home • Long-term care facility or nursing home • Deceased • Jail, prison, or juvenile detention facility
1b	SSO- HOUSING STABILITY:	SSO Q23c: Exit Destination

Criterion #	Criterion	Calculation
	SSO: % of all participants/leavers placed into Emergency Shelter, Transitional Housing or Permanent Housing (SSO-Street Outreach only)	<u>Numerator:</u> (Q23c-Total persons exiting to permanent housing destinations) + (Q23c-Total persons exiting to Transitional Housing) + (Q23c - Emergency shelter) <u>Denominator:</u> (Q23c-Total persons) – (Q23c- Total persons whose destinations excluded them from the calculation) - (Q23c Jail, prison, or juvenile detention facility) – (Q23c Client Doesn't Know/Client Refused) <u>Note:</u> Individuals who exit to any of the below listed “destinations” will be removed from the calculation and therefore will not count negatively towards this outcome: • Hospital or other residential non-psychiatric medical facility • Foster care home or foster care group home • Long-term care facility or nursing home • Deceased • Jail, prison, or juvenile detention facility
1c	PSH - HOUSING STABILITY/EXIT TO OR RETENTION IN PERMANENT HOUSING: PSH: % of all project participants stayers remained in PSH project or all project participants/leavers exited to other permanent housing.	PSH Non-DV/Non-Youth Dedicated Projects APR Q5 Report Validation Table; Q22a1: Length of Participation – CoC Projects; Q23c: Exit Destination <u>Numerator:</u> (Q22a1 Stayers-Total) + (Q23c-Total persons exiting to positive housing destinations) <u>Denominator:</u> (Q5a-Total persons served) - (Q23c- Total persons whose destinations excluded them from the calculation) - (Q23c Jail, prison, or juvenile detention facility) – (Q23c Client Doesn't Know/Client Refused) DV/Youth Dedicated Projects APR Q5 Report Validation Table; Q22a1: Length of Participation – CoC Projects; Q23c: Exit Destination <u>Numerator:</u> (Q22a1 Stayers-Total) + (Q23c-Total persons exiting to positive housing destinations) + (Q23c- Total persons exiting to temporary housing destinations) <u>Denominator:</u> (Q5a-Total persons served) - (Q23c- Total persons whose destinations excluded them from the calculation) - (Q23c Jail, prison, or juvenile detention facility) – (Q23c Client Doesn't Know/Client Refused) ----- <u>Note:</u> Individuals who exit to any of the below listed “destinations” will be removed from the calculation and therefore will not count negatively towards this outcome: • Hospital or other residential non-psychiatric medical facility • Foster care home or foster care group home

Criterion #	Criterion	Calculation
		• Long-term care facility or nursing home • Deceased • Jail, prison, or juvenile detention facility
2	RETURNS TO HOMELESSNESS: % returns to homelessness within 6 months of exit to permanent housing destination Note: Excludes DV Projects	SPM 2ab Data File – Returns to Homelessness <u>Numerator:</u> # of Clients w/Returns on Begin Date within 6 months of Exited on End Date and returned to ES, TH or SH project (Returns 10/1/24-9/30/25) <u>Denominator:</u> # Clients who exited from program to PH destination
3	DV-DEDICATED PROJECTS - QUARTERLY MONITORING	CoC records of submission of APR data on a quarterly basis, by stated deadline
4	LENGTH OF TIME BETWEEN PROJECT START DATE AND RESIDENTIAL MOVE IN % of households moved into housing in under 60 days (measured by days between project enrollment date and move in date)	Q22c: Length of Time between Project Start Date and Housing Move-in Date <u>Numerator:</u> (Q22c - Total 7 days or less) + (Q22c - Total 8 to 14 days) + (Q22c - Total 15 to 21 days) + (Q22c - 22 to 30 days) + (Q22c – 31 to 60 days) <u>Denominator:</u> Q22c - Total Persons Moved into housing *N/A for SSO
5	INCOME GROWTH/INCREASE TOTAL INCOME % of all adult participants who increased income from any source from entry to exit/annual assessment (leavers and stayers)	APR Q19a1: Client Cash Income Change – Income Source- by Start and Latest Status (Stayers); APR Q19a2: Client Cash Income Change – Income Source- by Start and Exit (Leavers); Q18: Client Cash Income Category - Earned/Other Income Category - by Entry and Annual Assessment/Exit Status <u>Numerator:</u> (Q19a1 Number of Adults w/Any Income-Performance Measure: Adults who Gained or Increased Income from Start to Annual Assessment, Average Gain) + (Q19a2 Number of Adults w/Any Income-Performance Measure: Adults who Gained or Increased Income from Start to Annual Assessment, Average Gain) <u>Denominator:</u> (Q18 Adults at Annual (Stayers)-Total Adults) + (Q18 Adults at Exit (Leavers)-Total Adults) – (Q18 Adults at Annual (Stayers)-Number of adult stayers not yet required to have an annual assessment) – (Q18 Adults at Annual (Stayers)-Client Doesn't Know/Client Refused) – (Q18 Adults at Exit (Leavers)-Client Doesn't Know/Client Refused)

Criterion #	Criterion	Calculation
6	EMPLOYMENT INCOME GROWTH: % of all adult participants who increased employment income from entry to exit/annual assessment (leavers and stayers)	APR Q19a1: Client Cash Income Change – Income Source- by Start and Latest Status (Stayers); APR Q19a2: Client Cash Income Change – Income Source- by Start and Exit (Leavers); Q18: Client Cash Income Category - Earned/Other Income Category - by Entry and Annual Assessment/Exit Status <u>Numerator:</u> (Q19a1 Number of Adults w/Earned Income-Performance Measure: Adults who Gained or Increased Income from Start to Annual Assessment, Average Gain) + (Q19a2 Number of Adults w/Earned Income-Performance Measure: Adults who Gained or Increased Income from Start to Annual Assessment, Average Gain) <u>Denominator:</u> (Q18 Adults at Annual (Stayers)-Total Adults) + (Q18 Adults at Exit (Leavers)-Total Adults) – (Q18 Adults at Annual (Stayers)-Number of adult stayers not yet required to have an annual assessment) – (Q18 Adults at Annual (Stayers)-Client Doesn't Know/Client Refused) – (Q18 Adults at Exit (Leavers)-Client Doesn't Know/Client Refused)
7	PARTICIPANTS w/ANY INCOME: % of adult participants with 1+ source of income (leavers and stayers)	APR Q18: Client Cash Income Category - Earned/Other Income Category - by Entry and Annual Assessment/Exit Status Numerator: (Q18 Adults at Annual (Stayers)-1 or more source of income) + (Q18 Adults at Exit (Leavers)-1 or more source of income) Denominator: (Q18 Adults at Annual (Stayers)-Total Adults) + (Q18 Adults at Exit (Leavers)-Total Adults) – (Q18 Adults at Annual (Stayers)-Number of adult stayers not yet required to have annual assessment) – (Q18 Adults at Annual (Stayers)-Adults with Client Doesn't Know/Client Refused Income Information) – (Q18 Adults at Exit (Leavers)-Adults with Client Doesn't Know/Client Refused Income Information)
8	PARTICIPANTS CONNECTED TO MAINSTREAM BENEFITS: Percentage of adult participants with 1+ source of Non-Cash benefits (SNAP, WIC, TANF, others, etc.)	APR Q20b: Number of Non-Cash Benefit Sources; APR Q18: Client Cash Income Category - Earned/Other Income Category - by Entry and Annual Assessment/Exit Status <u>Numerator:</u> (Q20b Benefit at Latest Annual Assessment for Stayers-1 + Source(s)) + (Q20b Benefit at Exit for Leavers-1+ Source(s)) <u>Denominator:</u> (Q20b Benefit at Latest Annual Assessment for Stayers-Total) + (Q20b Benefit at Exit for Leavers-Total) – (Q18 Number of Stayers-Number of adult stayers not yet required to have an annual assessment) – (Q20b Benefit at Latest Annual Assessment for Stayers-Client Doesn't Know/Client Refused) – (Q20b Benefit at Exit for Leavers-Client Doesn't Know/Client Refused)
9	PARTICIPANTS CONNECTED TO HEALTH INSURANCE: Percentage of all participants with 1+ source of health insurance	APR Q21: Health Insurance; APR Q5: Report Validation Table <u>Numerator:</u> (Q21 Latest Annual Assessment for Stayers-1 Source of Health Insurance) + (Q21 Latest Annual Assessment for Stayers-More than 1 Source of Health Insurance) + (Q21 Exit for Leavers-1 Source of Health Insurance) + (Q21 Exit for Leavers-More than 1 Source of Health Insurance)

Criterion #	Criterion	Calculation
		<u>Denominator:</u> (Q5 Number of Stayers) + (Q5 Number of Leavers) – (Q21 Latest Annual Assessment for Stayers-Number of Stayers not yet Required to Have an Annual Assessment) – (Q21 Latest Annual Assessment for Stayers-Client Doesn't Know/Client Refused) – (Q21 Exit for Leavers-Client Doesn't Know/Client Refused)
10	HIGH QUALITY DATA ENTRY: % of Error Rate for the following data points entered into PA HMIS: A. PII - Name B. PII – Date of Birth C. PII – Race D. Destination E. Income and Sources at Entry F. Income and Sources at Annual Assessment G. Income and Sources at Exit	APR Q6a. Data Quality: Personally Identifiable Information a. Name - % of Error Rate b. Date of Birth - % of Error Rate c. Race/Ethnicity - % of Error Rate Note: If Personally Identifiable Information fields are marked as Client Doesn't Know/Refused due to domestic violence survivor not providing data due to confidentiality/safety concerns, this will be factored into scoring and projects will not be penalized. APR Q6c. Data Quality: Income and Housing Data Quality d. Destination - % of Error Rate e. Income and Sources at Entry - % of Error Rate f. Income and Sources at Annual Assessment - % of Error Rate g. Income and Sources at Exit - % of Error Rate Note: Projects with no entries won't be scored on e (Income and Sources at Entry) and projects with no exits won't be scored on d (Destination) and g (Income and Sources at Exit)
11	TIMELINESS OF HMIS DATA ENTRY a. % of project entry records entered into HMIS within specified benchmark b. % of project exit records entered into HMIS within specified benchmark	APR Q6e: Timeliness a. <u>Numerator:</u> (Number of Project Start Records-0 Days + 1-3 Days + 4-6 Days + 7-10 Days) <u>Denominator:</u> (Number of Project Start Records-0 Days + 1-3 Days + 4-6 Days + 7-10 Days + 11+ Days) b. <u>Numerator:</u> (Number of Project Exit Records-0 Days + 1-3 Days + 4-6 Days + 7-10 Days) <u>Denominator:</u> (Number of Project Exit Records-0 Days + 1-3 Days + 4-6 Days + 7-10 Days + 11+ Days) Note: Projects with no entries won't be scored on 9.a. Projects with no exits won't be scored on 9.b.

Criterion #	Criterion	Calculation
12	PROJECT PARTICIPANT ELIGIBILITY: % of head of household (entering the project during the lookback period) whose prior living situation was reported as literally homeless situations or fleeing DV	Data from APR validation file will be reviewed to determine percentage of heads of household whose prior living situation was literally homeless OR participant reports currently fleeing DV. For DV providers using comparable database, RSF data reported by provider will be used to determine percentage of heads of household whose prior living situation was literally homeless OR participant reports currently fleeing DV. Numerator: # of heads of household enrolled between 10/1/24-9/30/25 who were literally homeless and/or fleeing DV at project entry Denominator: Total # of heads of household enrolled between 10/1/24-9/30/25 HUD Category 1/Literally Homeless Definition: Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution HUD Category 4/Fleeing Domestic Violence Definition Any individual or family who: (i) are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing
13	UNIT UTILIZATION RATE: Average utilization rate of project (using project utilization each quarter, as reported on APR)	APR Q8b Point-in-Time Count of Households on the Last Wednesday; 2025 Project App # Units <u>Numerator:</u> Average of Q8b Point-in-Time Count of Households Served on the Last Wednesday in Jan, April, July, October <u>Denominator:</u> # Units per 2025 Project Applications (and prior years where applicable) For projects under 10 units, will use a 3-year average if the project is under 85% utilization. *N/A for SSO

Criterion #	Criterion	Calculation
14	FUNDS EXPENDED % of grant funds expended	Review of eloccs and/or Sage spending data. Review of supplemental expenditure form with additional information/explanation if program did not meet expenditure threshold.
15	TIMELY APR SUBMISSION APR submitted within 90 days of end of grant	Review of Sage data
16	RHAB PARTICIPATION AND COC LEADERSHIP Participation in RHAB meetings and volunteer participation with CoC Committees and Sub-Committees	Review of RSF documentation submitted by agency, sign in records, online survey attendance submission from RHAB meetings, and documentation from CoC committee/subcommittee chairs
17	COC MEETING ATTENDANCE	Review of RSF documentation submitted by agency, meeting sign in records, and online survey attendance submissions
18	COC WEBINARS AND TRAININGS	Review of RSF documentation submitted by agency, webinar/training sign in records, and online survey attendance submissions
19 Not scored in 2026	COORDINATED ENTRY PARTICIPATION	• Participation in Case Conferencing – CE Regional Managers report of attendance • Record Referral Outcomes for All HMIS Referrals (Excluding Victim Service Providers) – Review of CE Referrals Report in HMIS • 100% Project Vacancies are Reported to and Filled Through CE Process (For Victim Service Providers this will be self-report) – Review of CE Referrals Report in HMIS vs. Enrolled Clients (CE Managers to review discrepancies and verify if referrals were sent for enrollments) Not scored in 2026
20	SERVICE PARTICIPATION REQUIREMENT	Review of RSF documentation submitted by agency
21	LATE SUBMISSION (Penalty) if required CoC Renewal Scoring Documents are submitted after deadline (unless provided an extension due to extenuating circumstances)	Review of Survey Submission Date

NEW PROJECT LOCAL COMPETITION SCORING TOOL

Below please find outlined which criteria meet HUD requirements as outlined in the NOFO. The full new project scoring criteria document can be found on the following pages:

1. **See new project scoring criteria document for the maximum points for each of the following:**
 - maximum points available for each project,
 - maximum points available for objective criteria to review, rate, and rank project applications,
 - maximum points available for system performance measures to review, rate, and rank project applications; and
 - maximum points available based on returns to homelessness performance, employment income performance, and supportive services participation requirements.
2. Objective criteria were used and account for at least 50% of total points available. The new project scoring tool identifies which criteria are objective. **Objective criteria make up 55 out of 100 points (55%) for new project scoring of non-SSO projects and 41 out of 82 points (50%) for new project scoring of SSO projects.**
3. System performance measures were used and account for at least 25% of the total points available. The new project scoring tool identifies which criteria are related to system performance. **System performance criteria make up 25 out of 100 points (25%) for new project scoring for new non-SSO projects and 25 out of 82 points (30.5%) for new SSO projects.**
4. For housing projects (PH-PSH, PH-RRH, TH, Joint TH/PH-RRH), measures were considered for: returns to homelessness; employment income; and supportive service participation requirements. **The following new project scoring criteria were related to those areas:**

Criteria #	Criteria	Max Points: PSH	Max Points: RRH	Max Points: TH
12	Returns to Homelessness	6	N/A – No New RRH	6
13	Employment Income	6	N/A – No New RRH	6
18	Service Participation Requirements	4	N/A – No New RRH	4
19	Service Participation Requirements Plan	3	N/A – No New RRH	3
26	Plan to Increase Employment Income	4	N/A – No New RRH	4

Applicants do NOT need to complete this scorecard.

It is provided to applicants for information purposes only.

This scorecard will be used by the Eastern PA CoC's Funding Committee to review, rank, and tier your project.

Projects must pass both the Project Eligibility Threshold Review for All Projects and the Project Type Quality Threshold Review applicable to the project type proposed.

Projects that pass both Threshold Reviews will then be scored using "New Project Scoring".

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
A. Applicant Experience & Capacity		10	10	0		0	0
1. Experience with project component type	• 0 points - no experience and not described • 1 point – has experience but limited and/or somewhat described • 2 points – has extensive experience and adequately described	2	2				
2. Experience with subpopulation and household composition (if applicable)	• 0 points - no experience and not described • 1 point – has experience but limited and/or somewhat described • 2 points – has extensive experience and adequately described Applicants for DV Bonus projects should address their experience in serving the specific target subpopulation and/or describe their partnership with local VSP.	2	2				
3. Program management and accounting systems	• 0 points if not described or adequate • 2 point if systems are described and adequate to administer the funds	2	2				

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
4. Capacity to administer and comply with federal funding	• 0 points – no experience with grants OR unresolved findings/outstanding debt/underspent funds with inadequate explanations • 2 points – experience with grants with adequate description and unresolved findings/ outstanding debt/underspent funds with adequate explanations • 4 points – experience with adequate description with no unresolved findings/outstanding debt/underspent funds	4	4				
B. Scope and Need		21	21	10	10	0	0
5. Complete Project Scope	• 0 points - Not described • 1 point - Scope is partially described • 2 points - Scope is thoroughly described	2	2				

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
6. Appropriateness of project	• 0 points if projected intervention does not match the CoC's needs or the needs identified and/or is not appropriate to the project type/funding opportunity • 3 points if the projected intervention somewhat matches the CoC's needs or the applicant's identified needs and is appropriate to the project type/funding opportunity • 5 points if project scale, project type, and service/project plan are appropriate based on CoC's needs or needs identified by the applicant and to the project type/funding opportunity Applicants for DV Bonus projects should address how the project will appropriately serve the specific target	5	5				
7. Strategic Partnerships	• 0 points - not described • 2 points - identifies at least one strategic partnership, somewhat described • 4 points - identifies more than one strategic partnership, nature of partnership thoroughly described Applicants for DV Bonus projects should address how partnerships are strategic in serving the specific target subpopulation.	4	4				
8. Reallocation Projects	• 5 points - if project has voluntarily reallocated renewal project to create a new high performing strategic project	5	5	5	5		

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
9. Priority Subpopulation	• 2 points - if project will primarily or exclusively serve families with children OR people who are aging/elderly. The application should adequately detail how it is designed the meet the needs of either of these subpopulations.	2	2	2	2		
10. Opportunity Zones	• 0 points if activities take place in Opportunity Zones • 1 point if between 25 and 50% of activities take place in Opportunity Zones • 2 points if more than 50% of activities take place in Opportunity Zones • 3 points if more than 75% of activities take place in Opportunity Zones	3	3	3	3		

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
C. Performance Outcomes		19	19	19	19	17	0
11. Good Standing/ Strong Outcomes	For applicants with existing CoC-funded projects: • 0 points if one or more CoC renewal projects scored in the bottom 20% of renewal projects in both FY 2025 & FY 2026 CoC scoring • 1 point if ZERO CoC renewal projects scored in the bottom 20% of renewal projects in FY 2025 or FY 2026 CoC scoring • 2 points if ZERO CoC renewal projects scored in the bottom 20% of renewal projects in both FY 2025 & FY 2026 CoC scoring For applicants with other similar projects (non CoC-funded): • 0 points if no outcomes data on similar projects is provided • 1 points if outcomes data on similar projects is provided but the outcomes are consistently below CoC averages for same/similar project types • 2 points if outcomes data on similar projects is provided and the outcomes meet/exceed CoC averages for same/similar project types For applicants w/no data available on similar projects/programs, score 0 out of 2	2	2	2	2		

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
12. Returns to Homelessness	For applicants with existing CoC-funded projects, HMIS data will be used to determine % Returns to Homelessness. Applicants with Non-CoC-funded projects will submit data: <u>Returned to Homelessness via Exit to Homeless Destination:</u> • 0 points if >5% leavers exited to a homeless destination from CoC or similar projects • 1 point if >0%-5% leavers exited to a homeless destination from CoC or similar projects • 2 points if 0% leavers exited to a homeless destination from CoC or similar projects <u>Returns to Homelessness within 12 months after Permanent Housing (PH) exit:</u> • 0 points if >11% leavers who exited to PH destination from CoC or similar projects returned to homelessness w/in 12 months • 1 point if 7%-11% leavers who exited to PH destination from CoC or similar projects returned to homelessness w/in 12 months • 2 points if <7% leavers who exited to PH destination from CoC or similar projects returned to homelessness w/in 12 months <u>Returns to Homelessness within 24 months after Permanent Housing</u>	6	6	6	6	6	

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
	(PH) exit: • 0 points if >16% leavers who exited to PH destination from CoC or similar projects returned to homelessness w/in 24 months • 1 point if 8%-16% leavers who exited to PH destination from CoC or similar projects returned to homelessness w/in 24 months • 2 points if <8% leavers who exited to PH destination from CoC or similar projects returned to homelessness w/in 12 months For applicants w/no data available on similar projects/programs: • 3 points for plan to increase the rate that program leavers who exited to PH destinations and do not return to homelessness w/in 24 months						

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
13. Employment Income	For applicants with existing CoC-funded projects, HMIS data will be used to determine % of Program Participants with Employment Income and Increased Employment Income. Applicants with Non-CoC-funded projects will submit data: <u>Leavers with a Source of Employment Income:</u> • 0 points if <20% CoC or similar project participants had a source of employment income upon exit • 1 point if 20%-50% CoC or similar project participants had a source of employment income upon exit • 2 points if >50% CoC or similar project participants had a source of employment income upon exit <u>Participants with Increase in Employment Income:</u> • 0 points if <10% CoC or similar project participants had a source of employment income upon exit • 2 point if 10%-20% CoC or similar project participants had a source of employment income upon exit • 4 points if >20% CoC or similar project participants had a source of employment income upon exit For applicants w/no data available on similar projects/programs: • 3 points for plan to increase the rate that program leavers exit with employment income	6	6	6	6	6	

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
14. Successful Exits	For applicants with existing CoC-funded projects, HMIS data will be used to determine % of Program Participants with Exits to Permanent Housing. Applicants with Non-CoC-funded projects will submit data: <u>Transitional Housing:</u> • 0 points if <25% CoC or similar project participants exited to PH • 1 point if 25%-50% CoC or similar project participants exited to PH • 2 points if >50% CoC or similar project participants exited to PH <u>SSO/Street Outreach:</u> • 0 points if <10% CoC or similar project participants exited to PH • 1 point if 10%-25% CoC or similar project participants exited to PH • 2 points if >25% CoC or similar project participants exited to PH For applicants w/no data available on similar projects/programs: • 1 points for plan to increase the rate that program leavers exit to permanent housing	5	5	5	5	5	

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
D. Budget		14	14	9	9	0	0
15. Budget Completion	• 0 points if budget is incomplete and lacks the required detail • 2 points if the budget is complete but lacks the required detail • 4 points if the budget is completed in full and includes all the	4	4	4	4		
16. Budget is Consistent, Appropriate, & Cost Effective	• 0 points if budget is inconsistent with/inappropriate/not cost effective for the project as described in the application • 2.5 points if the budget has a few inconsistencies but is appropriate/cost effective as described in the application • 5 points if the budget is consistent, appropriate, and cost effective for the project as described in the application	5	5				
17. Investment in Supportive Services	• 0 points if the budget for supportive services is less than 20% of the total project budget • 2.5 points if the proposed budget for supportive services is between 20% and 30% of the total project budget OR between 30 and 50% of the budget + the value of match, leverage, or formal partnerships • 5 points if proposed budget for supportive services is more than 30% of the total project budget OR 50% of the budget + the value of match, leverage, or formal partnerships	5	5	5	5		

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
E. Supportive Services and Case Management		33	16	15	1	8	0
18. Service Participation Requirements	Project will implement service participation requirement • 0 points if “No” selected • 4 points if “Yes” selected N/A for SSO & SSO-SO	4		4			
19. Service Participation Requirements	Plan to implement service participation requirements. Plan should balance accountability but minimize client termination and returns to homelessness. • 0 points if not adequately described • 1.5 points if described in some detail but plan is somewhat adequate • 3 points if there is a specific plan described in detail that is appropriate N/A for SSO & SSO-SO	3					
20. Substance Use Treatment On-site	Substance use treatment is available on-site • 0 points if “No” selected • 3 points if “Yes” selected N/A for SSO & SSO-SO	3		3			
21. Sober Housing	This project is sober housing for people in recovery • 0 points if “No” selected • 1 point if “Yes” selected N/A for SSO & SSO-SO	1		1			

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
22. Required SUD Treatment	The purpose of the project is to provide substance abuse treatment services for people experiencing homelessness with participation required • 0 points if “No” selected • 2 points if “Yes” selected N/A for SSO & SSO-SO	2		2			
23. Drug Enablement	Project certifies it will comply with the CoC's policy prohibiting Drug Enablement • 0 points if “No” selected • 4 points if “Yes” selected N/A for SSO & SSO-SO	4		4			
24. Plan to Obtain/Retain Housing	• 0 points if not described • 2 points if described in some detail but plan is somewhat adequate • 4 points if there is a specific plan described in detail that sufficiently meets the need	4	4			4	

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
25. Appropriateness of services	• 0 points if not client-centered and/or plan for providing services is not addressed/inadequate • 2.5 points if client-centeredness and/or plan for providing services is somewhat addressed • 5 points if there is clear evidence of appropriate client-centered services AND a robust plan for providing services Applicants for DV Bonus projects should address how the services provided through the project are appropriate to the specific target subpopulation.	5	5				
26. Plan to increase employment income	• 0 points for no clear plan identified • 2 point for a plan somewhat articulated • 4 points for a clear plan with specific action steps	4	4			4	
27. Linkage to other resources	• 0 points for no clear plan identified • 1 point for a plan somewhat articulated • 2 points for a clear plan with specific action steps	2	2				
28. Linkage to Mainstream Benefits	• 0 points for linkages to less than 2 types of mainstream benefits • 1 point for linkages to more than 2 types of mainstream benefits	1	1	1	1		

Eastern PA CoC: FY26 New Project Proposal Scoring

Applicant:		Project Name:					
Project Passed New Project Threshold?		YES or NO					
SCORING		FY26 Max Points: Non-SSO	FY26 Max Points: SSO	Objective Points: Non-SSO	Objective Points: SSO	System Performance Measure Points: All	Application Score
TOTAL		100	82	55	41	25	0
F. Collaboration with People with Lived Experience		3	2	2	2	0	0
29. Person w/Lived Experience on Agency Board or Equivalent Policymaking Entity	• 0 points for No • 2 points for Yes with documentation provided	2	1	2	2		
30. Plan to engage people with lived experience in policy and program development throughout the	• 0 points for no activities or clear plan identified • 0.5 point for activities somewhat described/a plan somewhat articulated • 1 point for activities described in detail/a clear plan with specific action steps provided	1	1				

Eastern PA FY26 CoC Competition New Project Proposal - Project Eligibility Threshold Review

Applicant:	Project Name:				
Threshold Criteria	PASS	FAIL	N/A	Unsure	Notes
Application: Application was submitted on time and is complete.					
Eligible Applicant: Applicant and any subrecipients are a non-profit, state/local government, instrumentality of state/local government, public housing agency, public institution of higher education, Indian Tribe, or TDHE AND proof of eligibility was submitted					
Project Eligibility: Proposed project type is eligible for new project funding under the FY26 CoC Program NOFO and the Threshold CoC RFA.					
Eligible Geography: The project will take place within the geography of the CoC.					
Client Eligibility: The population to be served meets HUD CoC program eligibility requirements, and the project application clearly establishes eligibility of project applicants.					
Match: Match commitment letter is signed, subited on agency letterhead, and reflects the required match commitment (25% of total project budget, excluding leasing costs)					
Admin: Administrative costs are less than 10% of the total project budget, excluding leasing costs.					
HMIS: Project applicants (except for Planning funds) agrees to participate in a local HMIS system. If applicant is a victim service provider, they use/will use a comperable database that meets the needs of the local HMIS.					
Coordinated Entry: All housing project participants enrolled must come through referrals from the CoC's Coordinated Entry System, which maintains a centralized prioritization list.					
Illegal Discrimination: Project applicant affirms they will not engage in illegal racial discrimination, consistent with 2 CFR 200.300.a					

Eastern PA FY26 CoC Competition New Project Proposal - Project Eligibility Threshold Review

Applicant:	Project Name:				
Threshold Criteria	PASS	FAIL	N/A	Unsure	Notes
Drug Enablement: The project applicant will not operate drug injection sites or "safe consumption sites" in violation of 21 U.S.C. 856(a)(1), knowingly permit the use or distribution of illicit drugs on property under their control in violation of 21 U.S.C. 856(a)(2), or knowingly distribute drug paraphernalia in violation of 21 U.S.C. 863.					
Past Performance: Applicants with existing CoC grants have satisfactory performance, capacity, drawdowns, timely resolution of monitoring findings, ability to meet timeliness standards, and APRs were submitted on time.					

Eastern PA FY26 CoC Competition New Project Proposal - Project Type Quality Threshold Review

Applicant:		Project Name:	Type:	
Project Type	Points	Threshold Criteria	PASS	FAIL
New Transitional Housing		(must get 6 out of 8 points)	0	0
	2	The project will provide AND/OR partner with other organizations to provide eligible supportive services that are necessary to assist program participants to obtain and maintain housing (i.e., case management, behavioral healthcare, employment training, etc.)		
	1	The applicant has prior experience operating transitional housing or other projects that have successfully helped homeless individuals and families exit homelessness within 24 months OR has a plan in place to ensure homeless individuals and families will exit homelessness within 24 months.		
	1	The applicant has previously operated or currently operates transitional housing or another homelessness project, OR has a plan in place to ensure that at least 50 percent of participants exit to a positive destination within 24 months AND at least 50 percent of participants exit with employment income as reflected in HMIS or another data system used by the applicant.		
	1	The project will be supplemented with resources from other public or private sources , that may include mainstream health, social, and employment programs such as Medicare, Medicaid, SSI, and SNAP.		
	2	The project will assess service needs of program participants. The project will provide individualized services for program participants during their time in Transitional Housing. There will be at least 20 hours per week of engagement in services, activities, or employment. Exceptions can be made for those over the age of 62 or who have a "handicap" or developmental disability.		

Eastern PA FY26 CoC Competition New Project Proposal - Project Type Quality Threshold Review

Applicant:		Project Name:	Type:	
Project Type	Points	Threshold Criteria	PASS	FAIL
		Service plans will be created for each participant detailing the services to be provided (when, how often, by whom), participant goals, strategies for achieving goals, and target dates for achievement to focus on improved health, wellness, housing stability, increased employment income, financial stability, and self-sufficiency.		
	1	Applicant demonstrated the average cost per household served for the project is reasonable . 2 CFR 200.404.		
New SSO Standalone	(must get 4 out of 5 points)		0	0
	1	The Supportive Services project is necessary to assist people in exiting homelessness		
		The project addresses barriers to stable housing (e.g., substance use disorder, unemployment, childcare, etc.)		
		The project will increase self-sufficiency		
		The Recipient will conduct an annual assessment of the service needs of the program participants.		
	2	Project has a strategy for providing supportive services to eligible program participants		
		Project has strategies for engaging those who are unsheltered and who do not traditionally engage with services		
	1	The project will be supplemented with resources from other public or private sources , that may include mainstream health, social, and employment programs such as Medicare, Medicaid, SSI, and SNAP.		

Eastern PA FY26 CoC Competition New Project Proposal - Project Type Quality Threshold Review

Applicant:		Project Name:	Type:	
Project Type	Points	Threshold Criteria	PASS	FAIL
	1	Applicant demonstrated the average cost per household served for the project is reasonable . 2 CFR 200.404		
New SSO Street Outreach	(must get 5 out of 6 points)		0	0
	1	The project will be supplemented with resources from other public or private sources , that may include mainstream health, social, and employment programs such as Medicare, Medicaid, SSI, and SNAP.		
	2	Project has a strategy for providing supportive services to eligible program participants		
		Project has strategies for engaging those who are unsheltered and who do not traditionally engage with services		
	1	Applicant has a history OR a plan for partnering with first responders and law enforcement to engage people living in places not meant for human habitation to access emergency shelter, treatment programs, reunification with family, transitional housing, or independent living.		
		Applicant will cooperate and not interfere or impede with the enforcement of local laws (e.g. public camping, public drug use).		
		Applicant is willing to assist first responders in their efforts to engage homeless individuals.		
		Applicant has experience OR a plan for providing outreach services Consistent with activity description at 24 CFR 578.53(e)(13).		

Eastern PA FY26 CoC Competition New Project Proposal - Project Type Quality Threshold Review

Applicant:		Project Name:	Type:	
Project Type	Points	Threshold Criteria	PASS	FAIL
	1	Applicant has a plan for OR has demonstrated effectiveness at helping people successfully exit from places not meant for human habitation to emergency shelter, treatment programs, transitional housing, and permanent housing programs.		
	1	Applicant demonstrated the average cost per household served for the project is reasonable. 2 CFR 200.404		
DV Bonus Transitional Housing (must also pass general TH Threshold)	The project applicant must demonstrate experience serving individuals and families of persons experiencing trauma or a lack of safety related to fleeing or attempting to flee domestic violence , dating violence, sexual assault, or stalking, and their ability to house survivors and meet safety outcomes.			

FY 2026

PA-509 – Eastern Pennsylvania

Continuum of Care

1D-2c. Local Competition Selection Results

Documents include the following:

- **Page 2: Chart showing:**
 - **new projects, including CoC Planning;**
 - **renewal projects;**
 - **fully or partially reallocated projects;**
 - **rejected projects—include all projects your CoC rejected regardless of the reason for rejection;**
 - **renewal and replacement YHDP projects; and**
 - **Rural and Unsheltered Special NOFO projects**

PA-509 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Fitzmaurice Community Services, Inc	PA0214 - Pathfinders PSH	PH-PSH	95.6%	Accepted	1	\$301,229	
The Salvation Army, a New York Corporation	Allentown Hospitality House Permanent Housing Program	PH-PSH	93.0%	Accepted	2	\$235,532	
Housing Transitions, Inc.	PA0176 Nittany House Apartments	PH-PSH	92.9%	Accepted	3	\$317,631	
Tableland Services, Inc.	PA0705 Consolidated Permanent Supportive Housing with Disabilities	PH-PSH	91.3%	Accepted	4	\$478,537	
Catholic Social Services of the Diocese of Scranton, Inc.	PA0519-PSHP Pike County	PH-PSH	89.5%	Accepted	5	\$137,792	
Catholic Social Services of the Diocese of Scranton, Inc.	PA0386-Rural Permanent Supportive Housing	PH-PSH	88.2%	Accepted	6	\$162,043	
The Salvation Army, a New York Corporation	Salvation Army Carlisle PH Project	PH-PSH	87.4%	Accepted	7	\$98,624	
Housing Development Corporation of NEPA	PA0384 HDC SHP 3 2026	PH-PSH	86.2%	Accepted	8	\$214,734	
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing	PH-PSH	85.7%	Accepted	9	\$284,638	
Northern Cambria Community Development Corporation	PA0360 Independence Gardens	PH-PSH	85.0%	Accepted	10	\$338,129	
Catholic Social Services of the Diocese of Scranton, Inc.	PA0450-Susquehanna/Wayne PSHP	PH-PSH	84.1%	Accepted	11	\$148,012	
Housing Development Corporation of NEPA	PA0582 HDC SHP 6 2026	PH-PSH	83.5%	Accepted	12	\$206,403	
The Lehigh Conference of Churches	PA0222 - Pathways Permanent Supportive Housing Consolidation	PH-PSH	77.2%	Accepted	13	\$1,425,388	
Perry Housing Partnership	PA0177 Perry Veterans SHP	PH-PSH	75.5%	Accepted	14	\$57,505	
County of Franklin	PA0649 - Franklin/Fulton S+C Project	PH-PSH	73.2%	Accepted	15	\$454,869	
Housing Authority of the County of Cumberland	PA0447 - PSH Consolidated	PH-PSH	52.0%	Accepted	16	\$806,911	
Resources for Human Development, Inc.	PA0449-Crossroads Housing Bonus Expansion	PH-PSH	46.9%	Reduced Reallocated	17	\$760,568	(\$317,900)

PA-509 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Transitions of PA	PA1139 Transitions of PA PSH for Snyder and Northumberland Counties	PH-PSH	Not Scored: First-Time Renewal or Not Operational Entire Lookback Period	Accepted	18	\$93,887	
Center for Community Action	PA1062 Rural Set Aside PSH Hardwoods	PH-PSH	1st time renewal - SNOFO	Accepted	19	\$393,667	
Clinton County Housing Coalition, Inc.	Lincoln Apartments	PH-PSH	1st time renewal - SNOFO	Accepted	20	\$40,120	
Pennsylvania Coalition Against Domestic Violence	PA1088 Eastern PA CoC DV RRH Consolidation Renewal FY26	PH-RRH	59.7%	Accepted	21	\$7,377,216	
Commonwealth of Pennsylvania	PA0188 Commonwealth of PA HMIS (PA-509) FY2026	HMIS	Not Scored: CoC Infrastructure	Accepted	22	\$417,044	
United Way of Pennsylvania	PA 0736 - Connect To Home Coordinated Entry Project	SSO-CE	Not Scored: CoC Infrastructure	Accepted	23	\$687,125	
United Way of Pennsylvania	PA1084 Enhanced East CES	SSO-CE	Not Scored: CoC Infrastructure	Accepted	24	\$570,786	
Pennsylvania Coalition Against Domestic Violence	PA1119 Eastern PA CoC DV CE Extension Renewal FY26	SSO-CE	Not Scored: CoC Infrastructure	Accepted	25	\$349,176	
Pennsylvania Coalition Against Domestic Violence	PA0927 Coordinated Entry Specialist for Domestic Violence	SSO-CE	Not Scored: CoC Infrastructure	Accepted	26	\$95,294	
The Lehigh Conference of Churches	Pathways II Permanent Supportive Housing	PH-PSH	77.2	Accepted	27	\$853,743	\$853,743
Housing Transitions	PA0176 Nittany Housing Apartments Expansion	PH-PSH (Services Expansion)	92.9%	Accepted	28	\$30,020	
The Lehigh Conference of Churches	PA0222 Pathways Permanent Supportive Housing Consolidation Expansion	PH-PSH (Services Expansion)	77.2%	Accepted	29	\$69,700	
Clinton County Housing Coalition	PA1063 Lincoln Apartments PSH SS Expansion	PH-PSH (Services Expansion)	73.0%	Accepted	30	\$13,700	

PA-509 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Transitions of PA	PA0445 Transitions of PA Permanent Supportive Housing Expansion	PH-PSH (Services Expansion)	72.0%	Accepted	31	\$75,227	
The Lehigh Conference of Churches	PA0213 - Outreach and Case Management for the Disabled, Chronically Homeless	SSO	64.1%	Accepted	32	\$80,388	
Valley Youth House Committee, Inc.	PA0887 - Lehigh Valley TH for Youth	TH	66.1%	Accepted	33	\$776,717	\$776,717
Centre County Government	PA0814 Centre County Transitional Housing Program	TH	96.9%	Accepted	34	\$434,070	\$434,070
Center for Community Action	PA0661 South Central TH	TH	92.9%	Accepted	35	\$529,248	\$529,248
Center for Community Action	PA1138 Central Valley JMSU TH	TH	Not Scored - First-Time Renewal or Not Operational Entire Lookback Period	Accepted	36	\$414,045	\$414,045
Valley Youth House Committee, Inc.	PA0808 - Lehigh Valley TH for families	TH	87.40%	Accepted	37	\$397,703	\$397,703
Transitions of PA	PA0859 SUN Counties Transitional Housing for Survivors	TH	85.7%	Accepted	38	\$134,556	\$134,556
Tableland Services, Inc.	PA0366 Transitional Housing Project	TH	84.3%	Accepted	39	\$184,111	\$184,111
The Lehigh Conference of Churches	PA1029 - Pathways TH	TH	81.1%	Accepted	40	\$522,104	\$522,104
Center for Community Action	PA0372 Blair County TH	TH	74.8%	Accepted	41	\$1,300,063	\$1,300,063
Third Street Alliance for Women & Children	PA0811 Third Street Alliance Transitional Housing	TH	73.2%	Accepted	42	\$501,856	\$501,856
Service Access and Management Inc.	PA1031 Daybreak Transitional Housing	TH	68.5%	Accepted	43	\$197,045	\$197,045
Perry Housing Partnership	Perry County TH Program	TH	62.2%	Accepted	44	\$257,765	\$257,765
Monroe, County of	PA1087 - Pocono Mountains Transitional Housing Project FY2026	TH	59.3%	Accepted	45	\$313,371	\$313,371
New Bethany, Inc.	New Bethany Transitional Housing Project	TH	59.1%	Accepted	46	\$177,419	\$177,419

PA-509 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Clinton County Housing Coalition, Inc.	PA0966 Clinton County Transitional Housing Project	TH	49.6%	Accepted	47	\$269,146	\$269,146
Housing Authority of the County of Cumberland	PA0812 Transitional Housing	TH	47.2%	Accepted	48	\$208,542	\$208,542
Pennsylvania Coalition Against Domestic Violence	PA1137 FY26 NEW Eastern PA CoC DV TH	TH	First-Time Renewal or Not Operational Entire Lookback Period	Accepted	49	\$5,853,033	\$5,853,033
Bradford County Human Service Agency	Transitional Housing Project 2026	TH	81	Accepted	50	\$198,596	
Schuykill Community Action Agency	Bridge House Transitional Housing	TH	84	Accepted	51	\$421,457	
Community CARES	Community CARES Housing Connections	SSO - Standalone	81	Accepted	52	\$188,650	
Community CARES	Waypoint Transitional Housing	TH	81	Accepted	53	\$132,000	
New Hope Ministries	Pathways to Housing Stability	SSO - Standalone	85	Accepted	54	\$126,741	
Lebanon Rescue Mission	Safe Haven Partnership	DV TH	84	Accepted	55	\$487,823	
Servants to All	SSO-Street Outreach	SSO - Street Outreach	81	Accepted	56	\$109,018	
Women's Help Center	Cambria Somerset Supportive Services	SSO - Standalone	78	Accepted	57	\$171,988	
Women's Help Center	The Way Home Transitional Housing Project	TH	73	Accepted	58	\$218,160	
Housing Transitions	Housing Transitions Street Outreach	SSO - Street Outreach	86	Accepted	59	\$39,290	
New Bethany	New Bethany Southside Drop-in Center Supportive Services Project	SSO - Standalone	81	Accepted	60	\$177,419	
The Lehigh Conference of Churches	Street Outreach	SSO - Street Outreach	83	Accepted	61	\$141,182	
The Lehigh Conference of Churches	Daybreak Drop-In Center	SSO - Standalone	83	Accepted	62	\$184,137	

PA-509 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Center for Community Action	Eastern PA CoC Coordinated Entry	SSO - CE	Not Scored - Project approved by Gov Board: CoC Infrastructure	Accepted	63	\$1,300,000	\$ 317,900.00
Breaking the Barriers	BTB Transitional Housing	TH	73	Accepted	64	\$266,461	
Transitions of PA	Transitions of PA Supportive Services Only for Survivors	SSO - Standalone	82	Accepted	65	\$407,110	
Transitions of PA	Transitions of PA Regional Transitional Housing for Survivors	DV TH	78	Accepted	66	\$150,143	
Beahive Affordable Housing Outreach, Inc.	Hive Stability Program	SSO-Standalone	67	Accepted	67	\$33,000	
Commonwealth of Pennsylvania	2026 CoC Planning Grant	Planning	Not Scored	Accepted	Not Ranked	\$1,500,000	
Center for Community Action	PA0372 Blair CAP - Rapid Re-Housing Program	RRH	74.8%	Fully Reallocated	Not Ranked	\$0	\$ (1,300,063.00)
Center for Community Action	PA0661 Bedford, Fulton, Huntingdon 2024 RRH	RRH	92.9%	Fully Reallocated	Not Ranked	\$0	\$ (529,248.00)
Center for Community Action	PA1138 Central Valley JMSU RRH	RRH	First-Time Renewal or Not Operational Entire Lookback Period	Fully Reallocated	Not Ranked	\$0	\$ (414,045.00)
Centre County Government	PA0814 Centre County Rapid Re-Housing Program	RRH	96.9%	Fully Reallocated	Not Ranked	\$0	\$ (434,070.00)
Clinton County Housing Coalition	PA0966 CCHC Regional Rapid Rehousing FY2024	RRH	49.6	Fully Reallocated	Not Ranked	\$0	\$ (269,146.00)
County of Monroe	PA1087 - Pocono Mountains Rapid-Rehousing Project FY2024	RRH	59.3%	Fully Reallocated	Not Ranked	\$0	\$ (313,371.00)

PA-509 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Housing Authority of the County of Cumberland	PA0812 - Rapid Rehousing Cumberland Perry Lebanon	RRH	47.2%	Fully Reallocated	Not Ranked	\$0	\$ (208,542.00)
New Bethany, Inc.	PA1086 New Bethany Rapid Rehousing FY2024	RRH	59.1%	Fully Reallocated	Not Ranked	\$0	\$ (177,419.00)
Pennsylvania Coalition Against Domestic Violence	PA1137 FY 24 NEW Eastern PA CoC DV RRH	RRH	First-Time Renewal or Not Operational Entire Lookback Period	Fully Reallocated	Not Ranked	\$0	\$ (5,853,033.00)
Perry Housing Partnership	PA0514 Perry County Rapid Rehousing	RRH	62.2%	Fully Reallocated	Not Ranked	\$0	\$ (257,765.00)
Service Access and Management Inc.	PA1031 Rapid Re-Housing Franklin County	RRH	68.5%	Fully Reallocated	Not Ranked	\$0	\$ (197,045.00)
Tableland Services, Inc.	PA0366 SHP Rapid Re-Housing Project	RRH	84.3%	Fully Reallocated	Not Ranked	\$0	\$ (184,111.00)
The Lehigh Conference of Churches	PA1029 - Pathways RRH	RRH	81.1	Fully Reallocated	Not Ranked	\$0	\$ (522,104.00)
The Lehigh Conference of Churches	PA0215 LCHA S+C 2024	PSH	21.0%	Fully Reallocated	Not Ranked	\$0	\$ (319,678.00)
Third Street Alliance for Women & Children	PA0811_Third Street Alliance_Lehigh Valley Rapid ReHousing Program	RRH	73.2%	Fully Reallocated	Not Ranked	\$0	\$ (501,856.00)
Transitions of PA	PA0859 SUN Counties Rapid Re-Housing for Domestic Violence Victims	RRH	85.7%	Fully Reallocated	Not Ranked	\$0	\$ (134,556.00)
Valley Housing Development Corporation	PA0216-VHDC SHP #2/3 2024	PSH	23	Fully Reallocated	Not Ranked	\$0	\$ (534,065.00)

PA-509 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Valley Youth House Committee, Inc.	PA0808 - Lehigh Valley RRH for families	RRH	87.4%	Fully Reallocated	Not Ranked	\$0	\$ (397,703.00)
Valley Youth House Committee, Inc.	PA0887 - TH-RRH for Lehigh Valley Youth	TH-RRH	66.10%	Fully Reallocated	Not Ranked	\$0	\$ (776,717.00)

\$0

FY 2026

PA-509 Eastern Pennsylvania

Continuum of Care

2A-8b. FY 2026 HDX Competition Report

Documents include the following:

- **PA-509 2026 HDX Competition Report**

2026 HDX Competition Report

This workbook contains summary information about your CoC's data as it was entered into the HDX for your use as part of the 2026 Competition.

To Print this Workbook:

This document has been configured as printable with preset print areas of relevant sections. To print it, go to "File", then "Print", then select "Print Entire Workbook" or "Print Active Sheets" depending on your needs.

To Save This Workbook as a PDF:

Click the "File" Tab, then click "Save As" or "Save a Copy", then click "Browse" or "More Options" then select "PDF", click "Options", select "Entire Workbook", press "OK", and click "Save". These instructions may differ depending on your version of Microsoft Excel.

On Accessibility, Navigability, and Printability:

This workbook attempts to maximize accessibility, navigability, printability, and ease of use. Merged cells have been avoided. All tables and text boxes have been given names. Extraneous rows and columns outside printed ranges have been hidden.

For Questions:

If you have questions, please reach out to HUD via the "Ask a Question" page, <https://www.hudexchange.info/program-support/my-question/> and choose "HDX" as the topic.

2025 HDX Competition Report

2026 Competition Report - Summary

PA-509 - Eastern Pennsylvania CoC

HDX Data Submission Participation Information

Government FY and HDX Module Abbreviation	Met Module Deadline*	Data From	Data Collection Period in HDX
2025 LSA	Yes	Government FY 2025 (10/1/24 - 9/30/25).	November 2025 to January 2026
2025 SPM	Yes	Government FY 2025 (10/1/24 - 9/30/25).**	February 2026 to March 2026
2026 HIC	Yes	Government FY 2026. Exact HIC and PIT dates vary by CoC. For most CoCs, it was within the last 10 days of January, 2026.	March 2026 to April 2026
2026 PIT	Yes	Government FY 2026. Exact HIC and PIT dates vary by CoC. For most CoCs, it was within the last 10 days of January, 2026.	March 2026 to April 2026

- 1) FY = Fiscal Year
- 2) *This considers all extensions where they were provided.
- 3) **"Met Deadline" in this context refers to FY25 SPM submissions. Resubmissions from FY24 (10/1/2023 - 9/30/2024) were also accepted during the data collection period, but the previous year's submission is voluntary.

2025 HDX Competition Report

2026 Competition Report - LSA Summary & Usability Status

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

LSA Usability Status 2025

Category	EST AO	EST AC	EST CO	RRH AO	RRH AC	RRH CO	PSH AO	PSH AC*	PSH CO
Fully Usable	☒	☒	☒	☒	☒	☒	☒	N/A	☒
Partially Usable								N/A	
Not Usable								N/A	

Glossary: EST = Emergency Shelter, Save Haven, & Transitional Housing; RRH = Rapid Re-housing; PSH = Permanent Supportive Housing; AO = Persons in Households without Children; AC = Persons in Households with at least one Adult and one Child; CO=Persons in Households with only Children
*Usability was not determined for PSH-AC due to built-in conflicts between HOMES and HMIS. As

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than the look back stop date or client's date of birth, whichever is later.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.

Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client’s entry, exit, and bed night dates strictly as entered in the HMIS system.

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, and SH	4,900	63.2	35.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	5,443	82.7	43.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

b. This measure is based on data element 3.917

This measure includes data from each client’s Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client’s entry date, effectively extending the client’s entry date backward in time. This “adjusted entry date” is then used in the calculations just as if it were the client’s actual entry date.

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, SH, and PH (prior to “housing move in”)	5,505	208.8	90.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	6,026	219.6	100.5

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Measure 2: Returns to Homelessness for Persons who Exit to Permanent Housing (PH) Destinations

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range. Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

	Total # of Persons Exited to a PH Destination (2 Yrs Prior)	Returns to Homelessness in Less than 6 Months (0 - 180 days)		Returns to Homelessness from 6 to 12 Months (181 - 365 days)		Returns to Homelessness from 13 to 24 Months (366 - 730 days)		Number of Returns in 2 Years	
Metric	Count	Count	% of Returns	Count	% of Returns	Count	% of Returns	Count	% of Returns
Exit was from SO	103	5	4.9%	7	6.8%	17	16.5%	29	28.2%
Exit was from ES	1,373	130	9.5%	60	4.4%	67	4.9%	257	18.7%
Exit was from TH	227	7	3.1%	6	2.6%	16	7.1%	29	12.8%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	1,395	52	3.7%	47	3.4%	39	2.8%	138	9.9%
TOTAL Returns to Homelessness	3,098	194	6.3%	120	3.9%	139	4.5%	453	14.6%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

Please refer to PIT section for relevant data.

Metric 3.2 – Change in Annual Counts

This measures the change in annual counts of sheltered homeless persons in HMIS.

Metric	Value
Universe: Unduplicated Total sheltered homeless persons	5,443
Emergency Shelter Total	4,903
Safe Haven Total	0
Transitional Housing Total	758

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

This measure is divided into six tables capturing employment and non-employment income changes for system leavers and stayers. The project types reported in these metrics are the same for each metric, but the type of income and universe of clients differs. In addition, the projects reported within these tables are limited to CoC-funded projects.

Metric 4.1 – Change in earned income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	386
Number of adults with increased earned income	45
Percentage of adults who increased earned income	11.7%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	386
Number of adults with increased non-employment cash income	182
Percentage of adults who increased non-employment cash income	47.2%

Metric 4.3 – Change in total income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	386
Number of adults with increased total income	215
Percentage of adults who increased total income	55.7%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	413
Number of adults who exited with increased earned income	108
Percentage of adults who increased earned income	26.2%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Metric 4.5 – Change in non-employment cash income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	413
Number of adults who exited with increased non-employment cash income	77
Percentage of adults who increased non-employment cash income	18.6%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	413
Number of adults who exited with increased total income	176
Percentage of adults who increased total income	42.6%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Measure 5: Number of Persons who Become Homeless for the First Time

This measures the number of people entering the homeless system through ES, SH, or TH (Metric 5.1) or ES, SH, TH, or PH (Metric 5.2) and determines whether they have any prior enrollments in the HMIS over the past two years. Those with no prior enrollments are considered to be experiencing homelessness for the first time.

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

Metric	Value
Universe: Person with entries into ES-EE, ES-NbN, SH or TH during the reporting period.	4,803
Of persons above, count those who were in ES-EE, ES-NbN, SH, TH or any PH within 24 months prior to their entry during the reporting year.	931
Of persons above, count those who did not have entries in ES-EE, ES-NbN, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	3,872

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

Metric	Value
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	5,919
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	1,025
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	4,894

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD’s Homeless Definition in CoC Program-funded Projects

Measure 6 is not applicable to CoCs in this reporting period.

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

This measures positive movement out of the homeless system and is divided into three tables: movement off the streets from Street Outreach (Metric 7a.1); movement into permanent housing situations from ES, SH, TH, and RRH (Metric 7b.1); and retention or exits to permanent housing situations from PH (other than PH-RRH).

Metric 7a.1 – Change in SO exits to temp. destinations, some institutional destinations, and permanent housing destinations

Metric	Value
Universe: Persons who exit Street Outreach	710
Of persons above, those who exited to temporary & some institutional destinations	218
Of the persons above, those who exited to permanent housing destinations	169
% Successful exits	54.5%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Metric 7b.1 – Change in ES, SH, TH, and PH-RRH exits to permanent housing destinations

Metric	Value
Universe: Persons in ES-EE, ES-NbN, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	5,138
Of the persons above, those who exited to permanent housing destinations	2,183
% Successful exits	42.5%

Metric 7b.2 – Change in PH exits to permanent housing destinations or retention of permanent housing

Metric	Value
Universe: Persons in all PH projects except PH-RRH who exited after moving into housing, or who moved into housing and remained in the PH project	848
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	816
% Successful exits/retention	96.2%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

System Performance Measures Data Quality

Data coverage and quality will allow HUD to better interpret your SPM submissions.

Metric	All ES, SH	All TH	All PSH, OPH	All RRH	All Street Outreach
Unduplicated Persons Served (HMIS)	4,973	770	897	2,230	620
Total Leavers (HMIS)	4,303	501	176	1,156	415
Destination of Don't Know, Refused, or Missing (HMIS)	975	90	8	9	74
Destination Error Rate (Calculated)	22.7%	18.0%	4.6%	0.8%	17.8%

1,833

107

5.8%

2025 HDX Competition Report

2026 Competition Report - SPM Notes

PA-509 - Eastern Pennsylvania CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Notes For Each SPM Measure

Measure		Notes
Measure 1	No notes.	
Measure 2	No notes.	
Measure 3	No notes.	
Measure 4	No notes.	
Measure 5	No notes.	
Measure 6	No Notes. Measure 6 was not applicable to CoCs in this reporting period.	
Measure 7	No notes.	
Data Quality	No notes.	

2025 HDX Competition Report

2026 Competition Report - HIC Summary

PA-509 - Eastern Pennsylvania CoC

For HIC conducted in January/February of 2026

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current Non-VSP Beds in HMIS or Comparable Database	Total Year-Round, Current, Non-VSP Beds	Removed From Denominator: OPH EHV [†] Beds or Beds Affected by Natural Disaster*	Adjusted*** Total Year-Round, Current, Non-VSP Beds	Adjusted*** HMIS Bed Coverage Rate for Year-Round, Current Beds
ES	1,368	900	1,121	0	1,121	80.3%
SH	0	0	0	0	0	NA
TH	612	350	584	0	584	59.9%
RRH	1,379	923	938	0	938	98.4%
PSH	1,015	620	977	0	977	63.5%
OPH	225	66	225	82	143	46.2%
Total	4,599	2,859	3,845	82	3,763	76.0%

2025 HDX Competition Report

2026 Competition Report

PA-509 - Eastern Pennsylvania

For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, VSP Beds in an HMIS-Comparable Database	Total Year-Round, Current, VSP Beds	Removed From Denominator: OPH EHV [†] Beds or Beds Affected by Natural Disaster ^{**}	Adjusted*** Total Year-Round Current, VSP Beds	HMIS Comparable Bed Coverage Rate for VSP Beds
ES	1,368	247	247	0	247	100.00%
SH	0	0	0	0	0	NA
TH	612	28	28	0	28	100.00%
RRH	1,379	441	441	0	441	100.00%
PSH	1,015	38	38	0	38	100.00%
OPH	225	0	0	0	0	NA
Total	4,599	754	754	0	754	100.00%

2025 HDX Competition Report

2026 Competition Report

PA-509 - Eastern Pennsylvania

For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS-Comparable Database	Adjusted*** Total Year-Round, Current, Non-VSP and VSP Beds	HMIS and Comparable Database Coverage Rate
ES	1,368	1,147	1,368	83.85%
SH	0	0	0	NA
TH	612	378	612	61.76%
RRH	1,379	1,364	1,379	98.91%
PSH	1,015	658	1,015	64.83%
OPH	225	66	143	46.15%
Total	4,599	3,613	4,517	79.99%

2025 HDX Competition Report

2026 Competition Report - HIC Summary

PA-509 - Eastern Pennsylvania CoC

For HIC conducted in January/February of 2026

1) † EHV = Emergency Housing Voucher

2) *This column includes Current, Year-Round, Natural Disaster beds not associated with a VSP that are not HMIS-participating. For OPH Beds, this includes beds that are Current, Non-HMIS, and EHV-funded.

3) **This column includes Current, Year-Round, Natural Disaster beds associated with a VSP that are not HMIS-participating or HMIS-comparable database participating. For OPH Beds, this includes beds that are Current, VSP, Non-HMIS, and EHV-funded.

4) ***Adjusted bed counts exclude non-HMIS participating OPH EHV Beds and Beds Affected by Natural Disaster

5) Data included in these tables reflect what was entered into HDX 2.0.

6) In the HIC, "Year-Round Beds" is the sum of "Beds HH w/o Children", "Beds HH w/ Children", and "Beds HH w/ only Children". This does not include Overflow ("O/V Beds") or Seasonal Beds ("Total Seasonal Beds").

7) In the HIC, "Current" beds are beds with an "Inventory Type" of "C" and not beds that are Under Development ("Inventory Type" of "U").

8) For historical data: Aggregated data from CoCs that merged are not displayed if HIC data were created separately - that is, only data from the CoC into which the merge occurred are displayed. Additional reports can be requested via AAQ for any CoCs that have been subsumed into other CoCs.

2025 HDX Competition Report

2026 Competition Report - PIT Summary

PA-509 - Eastern Pennsylvania CoC

For PIT conducted in January/February of 2026

Submission Information

Date of PIT Count	Received HUD Waiver
1/21/2026	Not Applicable

Total Population PIT Count Data

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Emergency Shelter Total	1,362	1,396	1,386
Safe Haven Total	0	0	0
Transitional Housing Total	408	451	395
Total Sheltered Count	1,770	1,847	1,781
Total Unsheltered Count	492	478	529
Total Sheltered and Unsheltered Count*	2,262	2,325	2,310

- 1) *Data included in this table reflect what was entered into HDX 2.0. This may differ from what was included in federal reports if the PIT count type was sheltered only.
- 2) Aggregated data from CoCs that merged is not displayed if PIT data were entered separately - that is, only data from the CoC into which the merge occurred are displayed. Additional reports can be requested via AAQ for any CoCs that have been subsumed into other CoCs.

Total People Experiencing Chronic Homelessness

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Total Sheltered Count	162	129	125
Total Unsheltered Count	64	116	130
Total	226	245	255

FY 2026

PA-509 Eastern Pennsylvania

Continuum of Care

**3A-DP. Your CoC's Policy or Statement to
Advance Recovery**

Documents include the following:

- PA-509 Eastern PA CoC Policy on Illicit Drug Enablement



Eastern PA CoC Policy on Illicit Drug Enablement

Approved by Eastern PA CoC Governing Board, 9-23-26

Policy

The Eastern PA CoC prohibits CoC-funded housing projects from activities that enable illicit drug use.

All CoC-funded housing project grantees and subrecipients SHALL NOT:

1. Knowingly permit the use or distribution of illicit drugs within or on property under the control of the CoC-funded project;
2. Allow any CoC-funded housing project or property under the control of the project to operate as a “safe consumption site” or drug injection site for the use of illicit drugs, including intravenous drug use;
3. Knowingly distribute drug paraphernalia to program participants or other individuals within or on property under the control of the CoC-funded project, or through project-sponsored activities;
4. Conduct, permit, encourage, or allow any of the above activities under the pretext of harm reduction*.

None of the above constitute a requirement that program participants must be sober in order to receive assistance, participate in substance use treatment in order to receive assistance, or be evicted or exited from assistance for a first-time violation of a drug-related program policy or lease requirement. All program participants are to adhere to any and all stipulations regarding use of illegal substances per their lease or occupancy agreement.

Violation of Policy

Compliance to this policy will be reviewed through the CoC’s monitoring process. Projects determined by the CoC to be in violation of this policy may be subject to corrective action, reduced ranking score, conditional funding recommendations, reallocation consideration, or other remedies deemed appropriate by the CoC.

Making support services, including substance use treatment available

In responding to violations of drug-related policies or lease requirements, CoC-funded projects are encouraged to leverage supportive interventions to help clients maintain stable housing and avoid returns to homelessness whenever possible. Appropriate responses may include, but are not limited to, participant meetings, lease warnings, adjusting case management plans, referrals to substance use treatment, recovery supports, increased supportive services, or other appropriate corrective actions consistent with HUD and project requirements.

Limitations/ Restrictions

The Eastern PA Continuum of Care encourages the provision of a wide range of options for unstably housed individuals and families throughout the region to meet their individual preferences and needs, including sober living and recovery housing. The Continuum of Care will not restrict or prohibit CoC-funded housing projects that require program participants to be sober or to participate in treatment as a condition of assistance in accordance with 24 CFR 578.

*Note: The limitations surrounding “harm reduction” are specific to the examples provided in the policy section of this document - use/distribution of illicit drugs; operation of safe consumption sites; and distribution of drug paraphernalia. This policy does not seek to limit other forms of harm reduction such as the use of naloxone/Narcan, which is not considered to be an “illicit drug”, or other overdose prevention efforts. Further, this policy does not seek to limit the use of harm reduction strategies such as STI prevention/testing, tobacco cessation education, etc.