

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-601 - Western Pennsylvania CoC

1A-2. Collaborative Applicant Name: Commonwealth of Pennsylvania

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Commonwealth of Pennsylvania

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:

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- Frequently Asked Questions

1B-1.	Accountable Structure and Participation.	
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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)	No	
4.	Community Mental Health Center (CMHC)	Yes	1
5.	Disability Advocate(s)	Yes	0
6.	Disability Service Organization(s)	Yes	0
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	1
9.	Faith-based Organization(s)	Yes	1
10.	Homeless or Formerly Homeless Person(s)	Yes	1
11.	Hospital(s)	Yes	0
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	1
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Nonexistent	
14.	Law Enforcement	Yes	0
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	1

17.	State Government Staff/Official(s)	Yes	1
18.	State or Local Elected Public Official(s)	Yes	1
19.	Local Jail(s)	No	
20.	Mental Health Service Organization(s)	Yes	1
21.	Mental Illness Advocate(s)	Yes	0
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	1
28.	School Administrators/Homeless Liaison(s)	Yes	0
29.	School District(s)	Yes	1
30.	Street Outreach Team(s)	Yes	1
31.	Substance Abuse Advocate(s)	Yes	1
32.	Substance Abuse Service Organization(s)	Yes	1
33.	Universities	Yes	0
34.	Veteran Serving Organization(s)	Yes	1
35.	Agencies Serving Survivors of Human Trafficking	Yes	0
36.	Victim Service Provider(s)	Yes	0
37.	Domestic Violence Advocate(s)	Yes	1
38.	Other Victim Service Organization(s)	Yes	0
39.	State Domestic Violence Coalition	Yes	0
40.	State Sexual Assault Coalition	Yes	0
41.	Youth Advocate(s)	Yes	2
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.	Community Volunteer	Yes	1
47.			

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

A solicitation for membership occurs in advance of the CoC's meetings (which occur 2-4x/year). Additionally, CoC Membership is available for new members to join on a rolling basis. Membership information is made available on the CoC website & included in all CoC emails, which include a link to submit a membership application (form) and to receive all CoC distributed communications. CoC staff attend monthly county/regional housing/homeless coalition meetings & meetings w/potential partners across the 20-county region to share CoC updates/info & engage new members. Additionally, this year the Regional Housing Advisory Board (RHABs) moved to member-led spaces, and the Chairs and Vice Chairs have solicited members by reaching out to counties in their region.

The CoC's Governing Board has established a new non-profit – the Housing Coalition of Western PA – which has given the work of the CoC a larger platform for recruitment of general, committee, & Governing Board members.

Outreach occurs to specific sectors as needed. In the last year, the CoC has developed outreach materials for recruitment and onboarding materials to support the engagement and participation in CoC work among new members.

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

The CoC's full structure includes the Governing Board, Committees, Workgroups, regional groups (Northwest RHAB = 13 counties, Southwest RHAB = 7 counties), and county-level Local Housing Options Teams/ housing coalitions. CoC staff attend several county-level meetings each month, with the RHAB & CoC meetings occurring quarterly. During each of these meetings the CoC solicits feedback on standing agenda items & emerging needs.

County-level meetings include a wide range of participants including homeless providers, behavioral health partners, law enforcement, support staff from the courts, PHAs, county/municipal gov, & more. Regional CoC meetings primarily include homeless asst & reps that work closely w/the CoC. CoC-wide meetings are required for all CoC/ESG funded orgs, but are also attended by a range of CoC stakeholders.

The CoC's Gov Board includes 19 members & has prioritized the recruitment/selection of new members in ways to intentionally increase the representation on the Board, including first responders, drug & alcohol, workforce dev, & specialty courts. There are 4 designated seats on the Board for people w/ lived experience.

The CoC also revised recruitment for new Committee members, further increasing the array of orgs participating in the CoC & providing input. The CoC adopted three pillars: hope, housing, & healing. The pillar of hope focuses on prevention and diversion, and the pillar of healing focuses on recovery. This focus has been included in updated marketing materials, on social media, in the monthly newsletter, & in updated recruitment materials.

Collectively, this broader focus of the CoC has resulted in a more diverse array of individuals providing input regarding the CoC's needs, general performance, strategies, & priority setting process at meetings and events. This includes an increased awareness among individuals invested in the CoC's mission, including among those working outside of the homeless service system.

The CoC's current membership includes: homeless asst programs, including emergency shelters; law enforcement; workforce development; behavioral health; substance use treatment; aging; PHAs; probation/parole; entitlement jurisdiction; advocates; gender-based violence; veterans groups; youth-serving providers; faith-based orgs; fair housing; ECYEH coordinators & homeless liaisons; local/county/state government; education; people w/ lived experiences of homelessness; and more.

1B-4.	Public Notification for Proposals from Organizations Not Previously Awarded CoC Program Funding.	
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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 6/24/26 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. The webinar was recorded and shared on CoC website.

The 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 (472 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). FC's recommendations are presented to the non-conflicted members of the Governing Board (those that do not receive CoC funding) for final approval. During the 2026 local competition, the CoC received an application from The Lighthouse Foundation, a Christian outreach org w/a long history of providing transitional housing. This organization is not a current grantee, but was previously funded to provide TH through the Western PA CoC until 2015. This project was selected & is ranked on the priority listing.

To support new project applicants, the CoC hosted a number of 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, and more.

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

1B-5	Plan for Comprehensive Strategies for Reducing Homelessness.
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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 Western PA CoC has seen an increase in older adult homelessness. Households aged 55+ represent 17% of those accessing CE last year. Of those, 29% were unsheltered. 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 20 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 Executive Director of the Housing Coalition of Western PA 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
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1C. Coordination and Engagement

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	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?	13%

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 20 rural counties. These resources are primarily funded/overseen by PA Dept of Drug & Alcohol Programs (DDAP) thru Single County Authorities (SCA). 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. 27 projects on CoC's priority list are operated by County Gov BH/Human Services offices or their designated BH provider, which fund/oversee/provide local SUD services. In these communities, access to SUD treatment for people experiencing homelessness is integrated through the same offices. In other communities, access to these services may begin through CES, referrals from shelter providers or street outreach, &/or once enrolled into ESG/CoC-funded project. 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. All CoC-funded projects provide assessment & referrals to SU treatment when needed. These providers directly provide, or make connections to organizations that provide assistance accessing open in-patient treatment beds, transportation to access treatment, case management, system navigation and more. 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. HPS can provide connection to county assistance office to begin Medicaid enrollment, &/or provide connections to accessing SU treatment in each county. Ongoing assessment of need & referrals are made to SU treatment for all as needed in CoC-funded projects.

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 management to support each HH's efforts to maintain housing stability & pursue self-sufficiency. This includes providing referrals & connections to outpatient treatment for MH/SUD at a range of levels based on ASAM assessment. This includes psychosocial interventions, medication management, suicide prevention, recovery supports & more. Some organizations provide these services through their CoC-funded projects, while other organizations provide connections to these services through community referrals & coordination.

To provide access to a range of MH/SUD services, as quickly as possible, CoC-funded providers have partnerships with their 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 and crisis services, and other community-based recovery services.

To coordinate care among persons experiencing homelessness and BH/SUD needs, providers participate in county-level multidisciplinary teams that focus on individuals w/the most complex needs to ensure the resources needed to support recovery are in place. Cross-system coordination occurs at county-level Local Housing Options Teams as well.

CoC-organizations also hire Certified Peer Specialists (MH-focused) & Certified Recovery Specialists (SUD-focused) to support project participants. In addition, 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 behavioral health 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, through Pennsylvania'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.

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 and which are widely available through the behavioral health system as a Medicaid billable service.

Additionally, many CoC-funded projects have Certified Peer Specialists (CPS) and/or Certified Recovery Specialists (CRS) on staff to support project participants. CPS/CRS staff often supplement the work of case managers to support client needs.

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.

The CoC also funds navigation services, which include recovery-focused services, through its coordinated entry system and specifically for youth through YHDP-funded navigation projects.

CoC-funded organizations are also funded with PATH in 12 of the CoC's 20 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.

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.

CHAPS, a CoC-funded provider in Crawford County, intentionally recruits Board members in recovery/ lived experience (e.g. MH, SUD, forensic, history of homelessness, etc) & uses this same practice for hiring new staff. When existing staff in recovery express interest in becoming a certified peer, CHAPS covers the cost of the training. They have seen clients make significant progress on their goals w/assistance from peers, in part due to the power of being seen, heard & understood by someone who has been there.

Due to the benefits of peer support, individuals w/lived experience who are participating in the CoC's Youth Action Board & Homeless Action Board have been hired by CoC-funded organizations. This includes CHAPS, Westmoreland Community Action, & Union Mission. These staff work to support YHDP implementation & the operation of the Coordinated Entry 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 12 of our 20 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, the PSH projects operated by Community Connections of Clearfield/Jefferson Counties & Cameron/Elk Counties Behavioral & Development Programs.

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 Targeted Case Management, both of which are widely available throughout the CoC. There are five ACT teams operating across 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.

Coordination of care also occurs through interdisciplinary teams that meet to discuss the most complex cases. In these meetings, teams collaborate to discuss effective methods to help stabilize clients in the community.

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.

When an individual w/a SMI diagnosis or known/suspected BH needs becomes known to a CoC-funded provider, they are connected w/the county MH/BH office for assessment & connections to services. In 4 counties a BH organization is the CE access point, so SMI screening & treatment linkage occur at intake. CE case conferencing meetings include care coordination & outreach for clients w/SMI.

In 2026 the CoC completed a SAMHSA Mental Health Block Grant-funded Landscape Analysis & Navigation Guide focused on SMI, mapping PATH, crisis, court, & BH-MCO resources for frontline staff, which should further advance local coordination.

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)

Several counties throughout the CoC have Drug Courts, MH Courts, or other specialty courts. The Warren County Drug Court refers Drug Court participants who are experiencing homelessness and/or housing instability to the Warren Forest Warren-Forest Economic Opportunity Council (WFEOC) for housing assistance. EOC is the Community Action Agency for Warren & Forest counties. WFEOC operates multiple CoC-funded projects, operates a CE access site, PATH-funded services & more.

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)

In Warren County, the EOC receives direct referrals from the Drug Court. The EOC utilizes CoC-funded PSH, PATH outreach, & PHARE (PA housing trust fund) funded reentry transitional housing to provide assistance. Intensive Case Management services are also utilized to support these HHs. When an individual is referred to the EOC from the Drug Court, EOC also receives their court orders. The various entities involved – Drug Court, Probation/Parole, law enforcement, behavioral health, & EOC - operate in close partnership to support individuals meet these requirements, maintain sobriety, & avoid rearrest. If the Court orders include avoiding drugs, alcohol, or require curfews, EOC monitors compliance & reports violations to the Court. Lack of compliance w/Court orders may result in a hearing before the judge, followed by a weekend in jail (for example). The response is designed to be significant enough to discourage future violations, yet avoid reincarceration & removal from the community. Many individuals are required to participate in Intensive Outpatient (IOP) services 3 days/week for substance use treatment. The Court will often reduce charges (e.g. from felony to misdemeanor) &/or reduce fines for clients participating in IOP services. Drug Court clients with no/low income are provided w/community service opportunities. Each hour worked “pays” off \$18 in fines. This community service is coordinated & tracked through EOC. Upon conclusion of Drug Court requirements, EOC assists participants to obtain independent housing in the community. Short term rental assistance can be provided or up to 3 months. Many of the CoC’s 20 counties have Local Housing Options Teams and/or Criminal Justice Advisory Boards. In each of these community planning meetings, programs and partnerships like the EOC/Drug Court described above in Warren County. These meetings bring together representatives of the different systems to identify needs, solutions, funding sources, and to support implementation of appropriate interventions. This coordination has helped to support the identification of system gaps and corresponding solutions to help support access to immediate housing needs & to support the housing stability of individuals engaged in Drug Courts, Mental Health Courts, & other specialty courts.

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)

The Westmoreland Community Action Agency (WCA) provides a mobile crisis team & a crisis hotline, as well as short-term hsg (15-30 days) & TH for individuals who are experiencing homelessness w/MH diagnosis in need of stabilization services. CoC-funded providers in Westmoreland are supporting the planning to establish a new walk-in crisis center opening in 2027. This will include a 23-hour stabilization unit, case mngmt, outpatient MH/SUD services, & other crisis stabilization services.

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.	60

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)

PATH operates in 12 of the CoC's 20 counties by CoC-funded organizations, expanding the homeless response in those communities in a coordinated way. PATH projects conduct street outreach, CE assessments & enrollments, quickly connect unsheltered persons to resources. PATH also supports case management, including to persons in shelter, providing continuity of case management services from homeless to housing. PATH staff attend CoC case conferencing, support timely HMIS data entry, etc.

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's priority listing includes Johnny's Place Sober Living Home, a new project application from The Lighthouse Foundation. Johnny's Place is a recovery-focused transitional housing option for men. The purpose of Johnny's Place is to provide a safe, drug-free environment where residents can focus on their recovery and work on their goals without being surrounded by the things that led to or kept them in addiction.

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), Local Housing Options Teams (LHOTs), & county-level task forces that focus on 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 some emergency housing resources that are allocated in coordination with CoC-funded providers, who help to coordinate appropriate services through warm handoffs.

Some of the street outreach teams include mental health workers who will remain involved with an individual until warm hand off to housing providers can occur.

1C-2.	Supportive Services Investment.	
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	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$28,861,571
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.	\$12,692,890
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	44%
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.	\$2,917,745
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).	54%

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%
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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)

DCED is the State ESG Recipient, the CoC's Collaborative Applicant (CA) & holds a seat on CoC Governing Board, Governance Committee & Funding Committee.

Annually, DCED updates their method of distribution under their annual action plan process which indicates their priorities and allocation plan for funding allocation and allows for public comment. The CoC shares opportunities for public comment & meetings w/membership. Historically, non-entitlement areas receive priority, which includes 18 of the CoC's 20 counties.

To ensure consistency across funding sources, PA DCED requires ESG subrecipients to participate in CoC planning, follow CoC Written Standards, participate in Coordinated Entry, & attend CoC-sponsored training. ESG-funded regional projects are incentivized to fill service gaps across the CoC, support smaller/ more rural counties that lack capacity to apply directly for ESG-funding & allocate resources in real time where needs emerge. To further coordination efforts, ESG applicants must provide a letter of support from the CoC.

Washington & Westmoreland counties are the CoC's other ESG recipients. Representatives from each county are represented on the CoC Gov Board. ESG Coordination between these jurisdictions & the CoC occurs at county level, where reps present the plan to CoC members for input & sign-off. DCED uses performance data generated from HMIS in the evaluation of projects. The CoC facilitates a year-round monitoring process for CoC- & ESG-funded projects to evaluate performance & data quality each quarter. This process supports the CoC's submission of strong & accurate data for the SPM, LSA, CAPER reports, as well as increasing the accuracy of data for the evaluation of projects. PA DCED also participates on CoC Funding Committee, which results in coordinated funding decisions.

The CoC conducts an annual gaps analysis using CES data, examining the LOT to PH, % households served, turnover in PH, & HIC data to ID needed resources. The gaps analysis, as well as county-level, regional & CoC-wide HIC/PIT data are provided to all ESG recipients.

DCED regularly engages CoC membership to provide input for the Con Plan, including the ID of community needs & priorities for CDBG, HOME, ESG, HTF & HOPWA. DCED also represents the CoC's needs & priorities as a representative of PA's new Interagency Council on Homelessness.

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 county LHOT meetings, 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. Washington & Westmoreland Counties (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 partners with PA CareerLink, One-Stop & PA OVR. YHDP providers (Westmoreland Community Action, CHAPS) connect youth/young adults to Workforce Development Board programs for skill building & job placement. The CoC's Governing Board includes a local Workforce Development Board's Executive Director.

CoC-funded organizations: hold 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. This is the model for many Community Action Agencies in the 20-county region that also provide housing and services to those experiencing or at risk of homelessness.

CoC is actively working to develop fellowship program for PWLE to bring them into workforce.

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)

The CoC's street outreach (SO) projects, funded by ESG, SSVF, PATH, VA & other resources, cover 100% of our 20-county area, with weekly/ on-demand SO occurring across 75% of the CoC. 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 include:

- Co-responder model in Lawrence Co. that pairs MH workers w/police to assist w/SO. Model based on MH First Aid concept. MH workers provide referrals & warm handoff to SO.

- Letter of Agreement b/w Westmoreland Community Action's Mobile Crisis Program & local LE. Agreement formalizes partnership w/goal to enhance LE response by providing clinical support during MH-related incidents, w/shared goal of promoting safety, reducing unnecessary hospitalizations or incarcerations, & providing connection to appropriate care.

- CHAPS has partnered w/ Meadville & Titusville LE to provide peer specialists for co-response & mobile support when police encounter person exhibiting MH struggles. This partnership has also included members of the CoC's HAB/YAB providing training to LE on the importance of understanding & responding differently to a MH crisis call vs a crime.

- Butler Co. has mobile crisis that train local LE around appropriate engagement.

- Cross-system training & information about resources occurs in many of the CoC's 20 counties, including Potter, Cameron & Elk.

- 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.

LE also often participate in case conferencing of complex cases to identify needs of persons w/frequent service engagement, including w/LE.

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 system navigation & 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, in partnership with local PHAs, also uses FUP vouchers to support family reunification efforts. 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. This includes discharge planning & helping individuals returning from institutions (e.g. incarceration, treatment, etc) return to family and/or their support network. YHDP-funded providers also 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. Additionally, the CoC's Written Standards require YHDP/ youth-dedicated projects to foster permanent connections through reunification, family finding, mediation, & family engagement services.

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.

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 Western PA CoC (PA-601) cooperates with, and does not interfere with or impede, local public safety efforts, and assists first responders serving people experiencing homelessness.

COOPERATING/ASSITING FIRST RESPONDERS:

The CoC, including CoC members and funded service providers, actively cooperate and collaborate with a range of public safety. Collaborative initiatives vary across the 20 counties that comprise the CoC geography, including various co-response initiatives between street outreach, behavioral health providers, police, and first responders. In Westmoreland, a mobile crisis program, operated by CoC-funded Westmoreland Community Action, has established a formal working relationship with the local police department to support individuals experiencing mental health crises within the county, including responding to acute needs of unhoused individuals experiencing SMI/SUD. This collaboration features on-scene response, consultation, coordination of care, and referral to ongoing services. The Warren Forest Local Housing Options Team (LHOT) features participation from local law enforcement and formal agreements with both police and jails that promote effective coordination. The CoC has actively participated in cross-training efforts between homeless service providers and law enforcement, including a recent 3-hour session at the state's largest housing conference. Local law enforcement also assists with the CoC's Point-in-Time Count, which has helped to promote effective count coverage and strengthened relationships. The 2026 Western PA CoC Landscape Analysis identified opportunities to expand CoC collaboration with law enforcement, including formalizing court-to-CE pathways, pursuing state-funding mechanisms to increase cross-system coordination, establishing formal connections with county-level discharge planners, and formalize relationships with criminal justice entities.

NON-INTERFERENCE:

No CoC governance document or policy restricts law enforcement and first responders from enforcing/leveraging laws regarding public camping, illicit drug use, involuntary commitment, or sex offender registration.

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)

As indicated in 1C-10b, there is minimal presence of encampments and tents across the CoC. The majority of unsheltered homelessness and encampments are in more urban areas of the CoC, such as Lawrence, Crawford, Warren, Washington, and Westmoreland Counties. Pennsylvania does not have a single statewide anti-camping ban causing variation in municipal laws, policies, and practices for addressing encampments. Most counties don't have explicit "anti-camping statutes" and instead leverage laws against "disorderly conduct" or "nuisance abatement, such as Greenburg in Westmoreland. Many also leverage park regulations, such as Washington County, which prohibits people from camping, setting up tents/temporary shelters in parks, or parking vehicles at parks overnight. Heavily wooded counties (e.g. Forest, Elk, Cameron, McKean, Potter Counties) rarely have municipal ordinances in place to address encampments. In these areas, encampments are often addressed for State Forest Regulations (17 Pa. Code § 21.117), which prohibit primitive and motorized camping on PA State Forest lands without a valid permit if the stay exceeds one night.

Significant variation in encampment response strategies and enforcement mechanisms have hindered the CoC's ability to create comprehensive and unified strategies across the region. In this next year, the CoC will work to strengthen involvement of municipalities, local law enforcement, and street outreach within Local Housing Options Teams (county-level groups) and Regional Homeless Advisory Boards (Northwest and Southwest RHABs). The goal of this collaboration will be to develop targeted strategies for reaching functional zero for unsheltered homelessness within each county and region within the CoC. A bi-product of this effort should be to train those on the ground in each community to appropriately leverage local laws to mitigate the presence of encampments and create effective referral pathways towards shelter, housing, and treatment. The CoC will work to strengthen data collection and sharing to effectively monitor outcomes that result from local encampment response efforts.

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)

Unsheltered homelessness in the CoC is modest in number, dispersed across 20 mostly rural counties, and not concentrated in large encampments. Many unsheltered individuals reside in vehicles, abandoned structures, wooded areas, etc., rather than concentrated in large visible encampments. The Western PA CoC 2026 PIT count found 75 unsheltered people in 57 households, 8.7% of the 860 people counted. Compared with 89 people in 74 households (10.1% of 877) in 2025, this data reflects a 16% decline. The majority of counties within the CoC counted fewer than 5 people within their geography on the night of the PIT, reflecting the spread-out nature of unsheltered homelessness in the region. The Washington and Westmoreland counties identified the most people on the night of the PIT (22 and 21 respectively), however, none of the individuals counted were living in congregated encampments with more than 5 individuals.

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/Policies/Practices:: 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 PA'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 w/in the CoC & offer a mechanism for law enforcement interventions. In counties w/strong partnerships between law enforcement, justice systems, behavioral health providers, and CoC providers, these laws offer an effective mechanism for promoting connections to SUD treatment and housing interventions. Indeed, several counties throughout the CoC have Drug Courts that leverage laws to direct people to needed assistance. For ex, the Warren County Drug Court refers participants who are experiencing homelessness and/or housing instability to the Warren Forest Warren-Forest Economic Opportunity Council (WFEOC) for housing/services assistance. WFEOC operates CoC-funded projects, a CE access site, PATH-funded services & more. Through this practice, those who use illicit drugs in public can be diverted to housing programs for more intensive supports.

Data: In 2025, 11 of 84 adults experiencing unsheltered homelessness on the PIT Count night were experiencing a SUD (13%), which dropped to zero (0) in the 2026 PIT. All individuals counted in 2026 who were experiencing SUD were identified in sheltered ES & TH settings. This reduction in the proportion of unsheltered individuals experiencing a SUD indicates effective progress in the CoC's efforts to divert individuals experiencing SUD to shelter, TH, and treatment settings.

Plan: CoC will further this progress by continuing to promote collaboration and co-response between street outreach, behavioral health providers, & law enforcement to identify & prioritize resources for unsheltered individuals experiencing SUD. Based on recommendation identified in the CoC's 2026 Landscape Analysis, the CoC will work to increase formal MOUs w/behavioral health & criminal justice providers, establish a relationship b/t CE & county mental health courts, & leverage new TH and treatment-focused programs to strive towards functional zero for unsheltered individuals w/SUD & reduce public illicit drug use.

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)

Data: 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 2,156 overdose victims within the counties that comprise the Western CoC. Overdoses within the CoC region maintained a 68% survival rate. Naloxone was successfully administered by EMS in 52% 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 Western PA PIT Count, 0 of 75 unsheltered adults were experiencing a SUD (0%). This was a dramatic decrease from the 2025 PIT Count which indicated 11 out of 84 of unsheltered adults experiencing a SUD (13%). This data shows promising progress in reducing, and potentially eliminating, 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 20 largely rural counties, where access to specialized behavioral-health services and transportation can vary substantially.

The 2026 PIT Count identified 860 people experiencing homelessness, including 198 adults with serious mental illness and 126 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 two 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 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 Western PA CoC's February 2025 Written Standards establish a complementary local practice: low barrier projects generally cannot screen people out based on criminal history, while recognizing exceptions required by federal, state, or local law. The Standards specifically permit emergency shelters serving families/children, or shelters whose locations create a legal residence restriction, to deny admission to a person registered under Megan's Law, while requiring that an alternative shelter be identified.

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 covers 100% of its 20-county geographic area to identify, engage & connect every person experiencing homelessness to shelter, treatment & services. Street outreach (SO) is funded through ESG, SSVF, PATH & VA. Weekly/ on-demand SO occurs in approximately 75% of the CoC's geo area, focused on known locations; in the remaining 25%, which is largely rural, SO responds to reports of unsheltered households. The annual unsheltered PIT count covers 100% of the CoC & informs where outreach is needed.

Language line, including ASL, is available to SO when needed.

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 12 of 20 counties targets people w/serious mental illness, 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. YHDP Youth Navigators visit identified youth hot spots.

SO staff complete CE assessments in the field, so no appointment, transportation or office visit is needed. 211 is available CoC-wide 24/7 by phone & text. SO workers provide tangible aid (food vouchers, sleeping bags, coats, hygiene items, transit passes) to build trust & sustain engagement.

In-reach into county jails, state prisons, treatment facilities helps to connect individuals to a housing destination prior to their release. This includes a connection to Medicaid & community-based treatment for those who need it so individuals don't relapse upon release.

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

The CoC has begun coordinating w/public libraries, often used as gathering spaces for people who are unsheltered.

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

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 Western 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. 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, regional & county-level meetings. Coordination around educational needs occurs 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. Community Action Agencies play a major role in the Western PA CoC's response to homelessness. Many CAAs directly provide early head start, head start, and other early childhood education programs, along with after school programming, to the benefit of families enrolled in homeless assistance programs.

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 20 rural counties to prevent homelessness among youth/ young adults w/history of child welfare and/or foster care involvement is a priority. The CoC has been working to increase this coordination for several years, beginning with the establishment of its Youth Action Board in 2018.

CoC providers in many counties work w/Children & Youth Services (CYS) caseworkers & Independent Living (IL) staff before youth age out, so housing, income, & service plans are in place at exit.

CoC providers have MOUs in place w/local PHAs for FYI voucher implementation. The CoC has provided TA to support FYI voucher requests, which include CYS & IL programs. McKean PHA has a preference for transition age youth & operates a youth-dedicated housing project locally funded. Multiple PHAs also have FUP vouchers to support aging out youth.

In 2024, the Western PA & Eastern PA CoCs jointly applied for & were awarded YHSI funding. While still in the implementation phase, YHSI goals include:

- Cross system data mapping/ analysis to better understand the flow of youth entering the homeless system from other "feeder" systems such as foster care, child welfare, juvenile justice, etc. This will allow the CoC to better coordinate, support discharge planning & prevention efforts.

- needs analysis to understand in greater detail the resources/ services/ assistance needed by youth to avoid homelessness, including w/CYS offices.

- Evaluate the CoC's Coordinated Entry System for youth friendliness & ease of navigation to identify recommendations for improvement.

- pilot project placing 10 youth in different communities across the 53 county (2 CoC) geography to support local efforts to address youth homelessness, such as engaging w/CYS in re:TAY.

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

The CoC was a round 4/5 YHDP community which increased youth-dedicated resources, including peer navigation support, host homes, TH & PSH. Peer navigation has provided the CoC with responsive/ mobile staff who can support youth experiencing or at risk of homelessness to be connected more quickly w/resources. The host home projects have enabled the CoC to provide a homelike setting for youth needing that type of support.

YHDP grantees also provide youth w/skill building opportunities, connections to employment, enrollment in GED, community/technical colleges & job training.

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)

The Western PA CoC has no RHY-funded providers within its jurisdiction. Through YHSI implementation, the CoC is working with RHY-funded providers operating in the Eastern PA CoC, including Valley Youth House, Centre County Youth Service Bureau, and Family Services, Inc. Each of these providers sit on the YHSI Core Team, which includes representatives from the Eastern and Western PA CoC and support the implementation of YHSI.

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)

The CoC currently funds six RRH projects that primarily serve families with children. This includes three projects operated by Lawrence County Social Services, Inc., two projects operated by the Pennsylvania Coalition Against Domestic Violence, and one project operated by Fayette County Community Action Agency, Inc.

Additionally, the CoC is submitting new applications for TH projects exclusively serving families with children.

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)

Lawrence County Social Services (LCSS) provides an integrated continuum of services that helps families experiencing homelessness achieve housing stability, economic self-sufficiency, and positive outcomes for their children. Through its CoC programs, including My First Place Rapid Re-Housing (RRH), TEAM RRH, and Veterans RRH, families receive housing assistance, intensive case management, and support in overcoming barriers that contribute to housing instability.

As families work toward long-term stability, LCSS connects parents and caregivers to workforce development and employment supports that increase household income and reduce the risk of future homelessness. Through the Human Services Development Fund (HSDF), participants receive individualized employment services, including resume development, job search assistance, job leads, mock interviews, soft skills development, and career coaching. HSDF staff also connect individuals to paid work experiences, vocational rehabilitation services through the Office of Vocational Rehabilitation (OVR), and other workforce partners that help remove barriers to employment and support career advancement. LCSS further strengthens employment outcomes through its partnership with the Pennsylvania Academic Career and Technical Training Alliance (PACTT), which provides opportunities for post-secondary education, industry-recognized credentials, and career and technical training that lead to sustainable employment and increased earning potential.

These services increase participants ability to obtain and retain employment, increase their income, and increase the likelihood that they will be able to sustain their housing long term.

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)

Lawrence County Social Services (LCSS) leverages a comprehensive network of mainstream family service systems to support participants enrolled in My First Place RRH, TEAM RRH, and Veterans RRH. Through coordinated case management, LCSS staff are COMPASS users, which allows staff to complete applications for various Mainstream benefits offered through the County Assistance Office, including TANF, SNAP, Medicaid, and childcare assistance. Staff also connect participants to workforce development services, PA CareerLink, and OVR, as well as behavioral health and substance use treatment providers, domestic violence services, public school supports, and other community resources. These mainstream resources allow participants to benefit from long term supports that can stabilize their home beyond the participation in the CoC programs.

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)

Lawrence County Social Services (LCSS) provides a coordinated continuum of services that addresses the complex needs of families with children experiencing homelessness. Through its CoC housing programs, including My First Place Rapid Re-Housing (RRH), TEAM RRH, and Veterans RRH, LCSS helps families quickly secure and maintain safe, stable housing while receiving individualized case management and connections to critical community resources.

Recognizing that housing stability is closely linked to family well-being, LCSS integrates supportive services across programs to address the needs of both parents and children. Families are connected to the SAFE Parenting Program. Supported by Lawrence County CYS, LCSS provides evidence-based parenting education designed to strengthen protective factors, enhance parenting skills, reduce family stress, and promote healthy parent-child relationships. Through its partnership with Adagio Health, LCSS also ensures families have access to health, nutrition, and wellness services that support physical and emotional well-being and remove barriers to long-term stability.

Children experiencing homelessness benefit from LCSS's early childhood education programs, including Head Start, Early Head Start, and Pennsylvania Pre-K Counts. These programs provide high-quality learning environments that promote school readiness, healthy development, and social-emotional growth while offering families additional support services and developmental screenings. Early childhood staff work closely with housing and family support programs to identify needs early and connect families to appropriate resources and create a combined service plan that lists comprehensive goals for each household.

By integrating housing assistance, parenting education, health services, and early childhood education, LCSS creates a seamless system of care that addresses both immediate crises and long-term family needs. This collaborative approach strengthens family stability, improves outcomes for children, and empowers families experiencing homelessness to achieve lasting self-sufficiency and success.

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)

The CoC has a very collaborative relationship with the Butler VAMC. Butler VAMC staff Co-Chair the CoC's Veterans workgroup (WG) & serve as Gov Board member. Veteran WG brings together all vet serving orgs to coordinate services through case conferencing & provision of resources. The CoC declared an end to veterans homelessness in 2019. Butler VAMC & WG collaborate to ensure benchmarks/criteria are still met by ensuring Veterans have the housing assistance & employment opportunities needed.

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 Western 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 TH, RRH, & PSH projects that serve survivors across the CoC. PCADV also participates in the CoC's Gender Based Violence Committee.

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)

The CoC's Reentry workgroup meets monthly & convenes ESG/CoC providers, housing providers, & justice system partners. This includes reps from the PA Dept of Corrections (DOC). DOC provides referrals to Fayette Co. Comm Action Agency's Home4Good funded RRH (through CoC) to support transition from prison to community.

Westmoreland CAA operates Re-Entry, a 3–6-month housing program for county residents exiting jail/prison/ or forensic history. Provides housing, on-site staff & support services.

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)

In Westmoreland Co. Union Mission supports individuals experiencing homelessness w/ complex medical needs through accessible shelter & coordinated care partnerships. Seton Hill University's Doctor of Physical Therapy program regularly brings students to the shelter to assess residents' needs, facilitate referrals & access to equipment/supports. Staff coordinate with County DHS & local clinicians to connect residents to home health & other services, including the local hospital as necessary.

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)

CoC-funded provider CONNECT partners w/the Area Agencies on Aging (AAA) in Washington, Greene, & Westmoreland Counties to serve aging and elderly individuals experiencing homelessness. Coordinated referrals connect participants to benefits, health & in-home supports, & assessments for appropriate levels of care. When independent housing is not appropriate, individuals are linked to personal care, assisted living, skilled nursing, or other residential options.

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)

The Western PA CoC dedicates all PSH units to chronic households. CoC-funded provider Connect, Inc. operates DWEL PSH (recipient), Washington Co. RRH One, Greene Co. PSH & other PSH projects as subrecipient. Connect, as an affiliate of Southwestern Pennsylvania Human Services, Inc., provides BH, SUD, recovery & case management services in locations across SW PA, including the operation of Centers of Excellence in 7 locations, which provides opioid-related substance use care.

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 DWEL Permanent Supportive Housing (PSH) project collaborates with Southwest Behavioral Care, DBA SPSHS Behavioral Health, to provide accessible, on-site behavioral healthcare services to program participants. Behavioral health (BH) services are available at the SPSHS SOR location in Greensburg, where Connect, Inc. case management services are also co-located. This integrated setting allows BH therapists to provide individual, couples, family, & group therapy on-site, as clinically appropriate. The co-location of BH & case management services promotes timely access to care & enhances coordination among providers. Connect case managers can collaborate directly with BH therapists to address participants' BH needs, reduce barriers to treatment, and support continuity of care. In addition, SPSHS Centers of Excellence (COE) opioid use disorder navigators, Drug and Alcohol case managers, and Certified Recovery Specialists are available to provide on-site recovery support, care coordination, and linkage to appropriate substance use disorder (SUD) treatment and recovery services. For DWEL PSH participants who are unable to access on-site BH or SUD treatment, COE navigators, case managers, and recovery specialists can directly link participants to telehealth treatment services available within SPSHS or through appropriate external BH and/or SUD providers. Staff assist participants in identifying appropriate providers, facilitating referrals, coordinating access to telehealth services, & addressing barriers that may otherwise prevent engagement in care. This provides participants with additional options for receiving timely BH regardless of transportation, mobility, scheduling, or other access barriers. COE navigators, D&A case managers, and recovery specialists can also provide community-based outreach to DWEL PSH participants at their residences or other appropriate community locations. These professionals assist participants with engagement in BH & SUD treatment, recovery supports, and services addressing social determinants of health. Through this collaborative & integrated approach, the DWEL PSH project provides multiple pathways to BH, including on-site treatment, telehealth services, community-based support, recovery services, & direct linkage to additional treatment providers. This approach reduces barriers to care while strengthening coordination among housing, case management, BH & SUD treatment, and recovery support providers.

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)

CONNECT Inc, as the subrecipient for Washington County Rapid Rehousing One, monitors individuals need for higher level of care (LOC). At times individuals may need assisted living, a residential treatment facility for substance use disorder (SUD), or inpatient stay.

CONNECT has a process for assessing participants throughout their enrollment to determine whether their current housing & supportive services continue to appropriately meet their needs. Through ongoing case management & participant contact, staff monitor changes in behavioral health (BH), substance use, physical health, functional abilities, activities of daily living (ADLs), safety, & overall ability to maintain independent housing.

When a participant demonstrates a potential need for a higher LOC, staff work w/ participant & appropriate providers to further assess & determine care needs. For participants experiencing an acute MH crisis or a significant change in BH needs, staff can coordinate directly w/ the SPHS CARE Center, which provides crisis services & can assess the participant's immediate BH needs, including whether a higher level of psychiatric care or inpatient hospitalization is indicated. This provides project participants w/ a direct pathway to crisis assessment & appropriate BH intervention when needed.

The project also coordinates w/ SPHS Area Agency on Aging (AAA) services in Washington Co. When a participant experiences changes related to aging, functional abilities, ADLs, or the ability to safely live independently, staff can coordinate w/the AAA for assessment, services, & linkage to an appropriate level of support. When indicated, this may include personal care, assisted living, skilled nursing, or other supportive living arrangements.

When a participant's needs are related to a SUD, staff can coordinate w/SPHS CARE Center Centers of Excellence (COE) navigators, Certified Recovery Specialists, or CARE Center Outpatient staff & other treatment providers to facilitate assessment & linkage to the appropriate level of treatment. This may include withdrawal management, residential SUD treatment, or other clinically appropriate treatment services.

Staff assist participants throughout the referral/transition process & coordinate w/ involved providers to promote continuity of care. This process ensures that participants whose BH, SUD, medical, aging, or functional needs exceed what can safely be supported through RRH are assessed & connected to the appropriate higher LOC.

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 Greene Co. PSH project, operated by SPHS Connect, Inc., serves individuals experiencing chronic homelessness who require supports to achieve & maintain housing stability.

The Greene County PSH project has a process for routinely assessing each participant's progress, ongoing need for PSH, and readiness to transition to unsubsidized or another permanent housing (PH) option when appropriate. Through ongoing case management & individualized service planning, staff work w/participants to establish & regularly review goals that promote increased independence & long-term housing stability. The assessment considers factors such as earned & other income, employment, benefits, financial stability, ability to independently manage monthly housing expenses, independent living skills, connection to healthcare & behavioral health services, recovery supports when applicable, natural & community supports, & the participant's ability to maintain housing w/a reduced level of supportive services.

As participants achieve greater stability, case managers intentionally engage them in conversations regarding their long-term housing goals & assess their readiness to move on from PSH. Staff work w/ participants to ID any remaining barriers to greater independence & develop specific goals to address those barriers. When appropriate, staff explore PH opportunities that may include unsubsidized rental housing, affordable housing, Housing Choice Vouchers or other rental asst, or another PH resource for which the participant qualifies. The assessment of readiness is individualized & considers the participant's progress toward self-sufficiency, current level of service need, ability to maintain housing stability, & whether an appropriate PH option is available. Participants who continue to require the intensive housing & services available through PSH remain connected to those services based upon their ongoing needs.

For participants who are ready to move on, Greene County PSH develops an individualized transition plan designed to promote a successful & sustainable transition. Staff assist w/housing identification & applications, income & benefits, employment resources, budgeting, landlord coordination, & connections to community-based supports. When appropriate, BH, SUD treatment, healthcare, employment, & other community supports are established prior to transition to reduce the risk of future housing instability or a return to homelessness.

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.	
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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.	
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	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
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1D-2b.	Notification to Community Members and Key Stakeholders by Email that the CoC-Approved Consolidated Application is Posted on the Website.	
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	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
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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
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1D-2d.	Projects Rejected/Reduced—Notification Outside of e-snaps.	
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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.	09/21/2026
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.	
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	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
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1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
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	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) The CoC's reallocation process is outlined in the Funding Policies, which is 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). The CoC identifies projects that were low performing, underspending, or had cost effectiveness concerns via the 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. The CoC's gaps analysis is also used to ID where funding is needed.

The CoC may consider reallocation based on the following factors: 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, and requests the grantee to provide a written response outlining plan to resolve. If performance does not improve after receiving this official notice, the CoC may consider the project for reallocation. Recommendations for full or partial reallocation are submitted by the Funding Committee to non-conflicted Board members for final approval.

Agencies w/ projects subject to reallocation are provided with an 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. This included several RRH projects, and older TH & SSO projects that needed to restructure their budgets.

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.	
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	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2021 and FY 2026?	Yes
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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
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2A-2.	HMIS Implementation Coverage Area.	
	Not Scored—For Information Only	

	Select from dropdown menu your CoC's HMIS coverage area.	Multiple CoCs
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2A-3.	PIT Count—Methodology Change.	
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	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 Western PA CoC 2025 PIT count found 89 unsheltered people in 74 households, 10.1% of the 877 people counted. Compared with 49 people in 40 households (6.3% of 877) in 2024, this data reflects an 81.6% increase. 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 the 2024 PIT, only 5 counties identified at least one encampment – and 6 counties in the 2025 PIT. In these respective counties, there were 44 unsheltered individuals counted in 2025 and 20 counted in 2024. Approximately 25% of the location data that was successfully collected for unsheltered individuals described a setting that would not traditionally be considered an encampment (e.g. person living in their vehicle). Location data was not available for every person counted so the CoC calculated that approximately 75% of individuals counted who were unsheltered were living in encampments (15 for 2024). To estimate the number of encampments, the CoC combined households data from the PIT with location/encampment descriptions from each county to generate an estimate of 11 encampments for 2024. The CoC believes the number of encampments increased between 2024 and 2025 due to an increase in the number of households, with the vast majority in Westmoreland County (20). In April 2024, the CoC established updated Coordinated Entry Policies, which included Access and Diversion strategies to strengthen referral strategies to prevent individuals from entering unsheltered homelessness. During the Access and Diversion phase, service providers collect HMIS data as immediately necessary to successfully identify participants, route them to emergency services, and provide Diversion services. This phase is followed by Rapid Exit protocols to utilize progressive engagement approaches. The implementation of these strategies have been limited in more rural areas of the CoC due to ongoing challenges with finding and maintaining engagement with individuals across such a wide geography. Many law enforcement entities indicate that most unsheltered individuals reside in remote areas far from city/town centers, posing challenges for engaging individuals who move around within the area. Ongoing collaboration with law enforcement and expansion of street outreach efforts have helped to increase engagement opportunities for those who are hardest to serve.

2A-4a.	Reduce Encampments—Number of Encampments.	
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1. Enter the estimated number of encampments in the beginning of your evaluation period.	11
2. Enter the reduction in the number of encampments during your evaluation period.	0

2A-4b.	Reduce Encampments—Number of People in Encampments.	
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1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	15
2. Enter the reduction in the number of people in encampments during your evaluation period.	0

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)

A significant contribution to the CoC's increase in the number of encampments and persons in encampments was the Westmoreland County unsheltered PIT increasing from 0 to 20 between 2024 and 2026. In 2026, Westmoreland Community Action (WCA), a CoC-funded agency, established letters of agreement between their Mobile Crisis Program and 17 law enforcement entities across the region within and surrounding Westmoreland County to strengthen collaboration in areas with encampment hotspots. These efforts have been targeted towards addressing behavioral health needs among people experiencing homelessness, in addition to increased coordination between the CoC and various law enforcement entities regarding encampment response. The CoC hopes to improve year-round data collection for unsheltered homelessness and encampments to ensure continuous reductions. The CoC will take advantage of the existing Regional Homeless Advisory Board infrastructure to facilitate regular reporting, debriefing, and strategizing among stakeholders. The CoC will work with municipalities, law enforcement, and service providers in rural areas within the CoC to achieve and maintain functional zero for unsheltered homelessness and encampments. The CoC will also work to assess whether there are seasonal changes in unsheltered homelessness, with a particular focus on creating methodologies for data collection in warmer months. The CoC will leverage existing success in Westmoreland to promote the involvement of local police within the Continuum of Care and identify opportunities for collaboration in other counties. The CoC will work to inventory laws and practices for addressing encampments in every county within the CoC to identify opportunities for improvement and share strategies across the region.

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)

Through CoC meetings & analysis of HMIS data, the following most significant risk factors for 1st time homelessness have been IDed: recent eviction; doubled up; exiting from institutions; transition age youth & older adults w/ limited income. The CoC's plan includes:

Prevention & diversion: All households entering CE receive up to 30 days of Housing Problem Solving (HPS) w/staff & flexible funds to resolve the crisis before shelter entry. CE assessment centers use state HAP, ESG, SSVF & other funds for eviction prevention, first month/security & landlord payment plans, & help recently evicted and doubled-up households reconcile w/family/friends. HPS will also provide referrals to mainstream resources, employment assistance, & behavioral health as needed.

Institutional discharge & justice partners: The CoC's CE & HMIS teams work w/PA DOC Reentry Managers & SCI social workers to plan housing before release. Barriers to housing include eligibility for CoC-funded projects, as well as timing between release & housing availability. The CoC will continue to examine opportunities to identify & secure alternate resources & address barriers through the work of its Reentry Workgroup.

Treatment & recovery: CoC will partner w/county Single County Authorities (SCAs) & PA DDAP to connect at-risk persons w/SUD to assessment, treatment funding & DDAP-licensed recovery houses. County MH offices, BH-MCOs & crisis providers will coordinate discharge plans for persons w/SMI.

Transition age youth: The CoC will continue to support the implementation & use of YDHP-funded projects. The CoC currently has a YHSI project working to better understand pathways into homelessness among youth, including CYS discharge. Once findings are presented, the CoC will work to develop strategies to prevent first-time homelessness for youth.

Older adults: The CoC will work to better understand the recent increases in older adult homelessness and 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:

- Expansion of street outreach services engage individuals with long histories of homelessness. This includes multiple new projects included on the 2026 priority list.
- 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 (non-VSP) 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 - CES assists providers with document readiness & leverages regional resources to facilitate an expedited PH placement. 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. Connections to employment & treatment programs even before housing placement occurs will assist with diversion efforts through opportunities to stabilize and increase income.

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?	66.11%	

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.). DV projects reporting in comparable databases were not included.

-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 1322.

-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 874.

-The outcome was calculated as follows: 874 exits to unsubsidized housing destinations from PSH, RRH, and TH projects / 1322 total exits from PSH, RRH, and TH projects = 66.11% 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: 499 exits to unsubsidized housing destinations from CoC-funded PSH, RRH, and TH projects / 734 total exits from CoC-funded PSH, RRH, and TH projects = 67.98% 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.	
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	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/21/2026
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2A-8a.	HIC and PIT Count Data—HDX 2.0 Submission Date.	
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	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
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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
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2A-8c.	System Performance Measures (SPM) Data—HDX 2.0 Submission Date.	
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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
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2A-9.	HMIS and Comparable Database Participation—Bed Coverage Rate.	
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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	629	190	446	54.46%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	270	10	115	41.07%
4. Rapid Re-Housing (RRH) beds	515	279	794	100.00%
5. Permanent Supportive Housing (PSH) beds	1,039	147	1,049	88.45%
6. Other Permanent Housing (OPH) beds	82	0	28	34.15%

2A-9a.	Partial Credit for Bed Coverage Rates of 84.99 Percent or Lower for Any Project Type in Question 2A-9.	
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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), & some PHAs (OPH). To increase HMIS coverage for ES, TH, & 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.
 - 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.
 - Governing Board has recently approved a system evaluation to launch in 2027 to review barriers to HMIS use & recommendations to improve HMIS bed coverage rates.
 - HMIS staff at PA DCED & CoC will continue to work w/PA DHS to require waiver service providers & all DHS-funded housing to use HMIS.

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.
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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	OnSite Substance ...	09/30/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	Require Substance...	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	HDX Competition R...	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	Policy or Stateme...	09/30/2026
11. Other	No		

Attachment Details

Document Description: OnSite Substance Use Treatment Attachment

Attachment Details

Document Description: Require Substance Abuse Treatment 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: HDX Competition Report Attachment

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Policy or Statement to Advance Recovery
Attachment

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/25/2026
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-601 – Western 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 2-5: Chart showing which PA-601 TH, PH-RRH & PH-PSH projects have on-site substance use treatment available, including the name of the treatment provider**

**PA-601 CoC: 1C-1. List of TH/RRH/PSH Projects and Treatment Providers
with On-Site Substance Use Treatment**

Number of TH, RRH, PSH Projects:	61
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	8
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	13%

Applicant Name	Project Name	Project Type	On-site Substance Use	Treatment Provider
Armstrong County Community Action of Pennsylvania	PA0274 - Armstrong County Permanent Supportive Housing Program	PSH	No	
Armstrong County Community Action of Pennsylvania	PA0776 - Transitional Housing Program of Armstrong County	TH	No	
Armstrong County Community Action of Pennsylvania	PA0716 - Family Transitional Housing Program of Armstrong County	TH	No	
Cameron/Elk Counties Behavioral & Developmental Programs	PA0307-AHEAD	PSH	No	
CAPSEA, Inc.	PA0311 Housing Plus	PSH	No	
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care	PSH	No	
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care Expansion	PSH	No	
CAPSEA, Inc.	Pathways to Housing Stability Project TH	TH	No	
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons	PSH	No	
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons Expansion	PSH	No	
Community Connections of Clearfield/Jefferson Counties	PA0459 Housing First	PSH	No	
Community Services of Venango County, Inc.	PA0424 Sycamore Commons	PSH	No	
Connect, Inc.	PA0904-DWEL	PSH	No	
County of Butler	PA0290 Path Transition Age Project	PSH	No	
County of Butler	PA0539 Home Again Butler County	PSH	No	
County of Butler	PA0287 HOPE Project	PSH	No	
County of Butler	PA0539 Home Again Butler County	PSH	No	
Greene County Human Services	PA0651-Greene County Shelter Plus Care Project	PSH	Yes	Connect Inc.
Greene County Human Services	PA0538-Greene County Supportive Housing Project	PSH	Yes	Connect Inc.

**PA-601 CoC: 1C-1. List of TH/RRH/PSH Projects and Treatment Providers
with On-Site Substance Use Treatment**

Number of TH, RRH, PSH Projects:	61
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	8
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	13%

Applicant Name	Project Name	Project Type	On-site Substance Use	Treatment Provider
Greene County Human Services	PA0780 Greene County Transitional Housing Project	TH	Yes	Connect Inc.
County of Washington	PA0291 - Permanent Supportive Housing	PSH	Yes	Connect Inc.
County of Washington	PA0296 - Shelter plus Care	PSH	Yes	Connect Inc.
County of Washington	PA0296 - Shelter plus Care Expansion	PSH	No	
County of Washington	PA1048 Washington Transitional Project	TH	Yes	Connect Inc.
County of Washington	PA1150 - Washington County SWPA Transitional Housing	TH	No	
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge	PSH	No	
Crawford County Mental Health Awareness Program, Inc	PA0460 - CHAPS Family Housing	PSH	No	
Crawford County Mental Health Awareness Program, Inc	PA0495 - Housing Now	PSH	No	
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care	PSH	No	
Crawford County Mental Health Awareness Program, Inc	PA1101 - Liberty House PSH	PSH	No	
Crawford County Mental Health Awareness Program, Inc	PA1055-Passages	PSH	No	
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge Expansion	PSH	No	
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care Expansion	PSH	No	
Crisis Shelter of Lawrence	Arise TH - Leasing	TH	No	
Crisis Shelter of Lawrence	PA1151 Arise DV PSH Project	PSH	No	
Crisis Shelter of Lawrence	PA0939-Arise TH Operating	TH	No	
Fayette County Community Action Agency, Inc.	PA0616-Fayette Apartments	PSH	No	
Fayette County Community Action Agency, Inc.	PA0560-Fairweather Lodge Supportive Housing	PSH	No	

**PA-601 CoC: 1C-1. List of TH/RRH/PSH Projects and Treatment Providers
with On-Site Substance Use Treatment**

Number of TH, RRH, PSH Projects:	61
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	8
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	13%

Applicant Name	Project Name	Project Type	On-site Substance Use	Treatment Provider
Fayette County Community Action Agency, Inc.	PA0846-FCCAA Transitional Housing Program	TH	No	
Housing Authority of the County of Butler Inc.	PA0493 - Franklin Court Chronically Homeless	PSH	No	
Indiana County Community Action Program, Inc.	PA0599 PHD Consolidated FY2026	PSH	No	
Lawrence County Social	PA0304-NWRHA	PSH	No	
Lawrence County Social	PA0425-Turning Point	PSH	No	
Lawrence County Social	PA0901-My First Place Youth Transitional	TH	No	
Lawrence County Social	PA0775-TEAM Youth Transitional Housing	TH	No	
Lawrence County Social	PA0718-Veterans Transitional Housing	TH	No	
McKean County Redevelopment & Housing Authorities	PA0778- Northwest Transitional Housing	TH	No	
Northern Cambria Community Development Corporation	PA0491 Chestnut Street Gardens PSH	PSH	No	
Pennsylvania Coalition Against Domestic Violence	PA0980 - West CoC Regional DV RRH FY26 Renewal	RRH	No	
Pennsylvania Coalition Against Domestic Violence	PA1149 FY26 New Western PA DV TH	TH	No	
Pennsylvania Coalition Against Domestic Violence	PA1191 FY26 New Western PA DV TH - 2	TH	No	
The Lighthouse Foundation	Lighthouse Foundation Transitional	TH	No	
Union Mission of Latrobe, Inc.	PA0540 - Union Mission Permanent Supportive Housing	PSH	No	
Victim Outreach Intervention Center	PA0280-VOICe-EnduringVOICe2026	PSH	No	
Victim Outreach Intervention Center	PA0280-VOICe-Enduring VOICe Expansion	PSH	No	
Warren-Forest EOC	PA0777 - Youngsville Permanent Supportive Housing	PSH	No	
Warren-Forest EOC	PA0897 - Warren Permanent Supportive Housing	PSH	No	
Westmoreland Community Action	PA0600 - WCA PSH	PSH	No	

**PA-601 CoC: 1C-1. List of TH/RRH/PSH Projects and Treatment Providers
with On-Site Substance Use Treatment**

Number of TH, RRH, PSH Projects:	61
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	8
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	13%

Applicant Name	Project Name	Project Type	On-site Substance Use	Treatment Provider
Westmoreland Community Action	PA1059 YHDP WCA TH	TH	No	
Westmoreland Community Action	Adult Regional TH - Recovery Focused	TH	Yes	Westmoreland Community Action
Westmoreland Community Action	Adult Regional TH	TH	Yes	Westmoreland Community Action

FY 2026

PA-601 – Western 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 2-5: Chart showing which PA-601 TH, PH-RRH & PH-PSH project units require substance use treatment, including the number of units**

PA-601 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:	126
Number of Units w/Required Substance Use Treatment:	60
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	1 : 2.1

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
Armstrong County Community Action of Pennsylvania	PA0274 - Armstrong County Permanent Supportive Housing Program	PSH	0
Armstrong County Community Action of Pennsylvania	PA0776 - Transitional Housing Program of Armstrong County	TH	0
Armstrong County Community Action of Pennsylvania	PA0716 - Family Transitional Housing Program of Armstrong County	TH	0
Cameron/Elk Counties Behavioral & Developmental Programs	PA0307-AHEAD	PSH	0
CAPSEA, Inc.	PA0311 Housing Plus	PSH	0
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care	PSH	0
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care Expansion	PSH	0
CAPSEA, Inc.	Housing Plus Pathways	TH	0
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons	PSH	0
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons Expansion	PSH	0
Commonwealth of Pennsylvania	PA0428 Commonwealth of PA HMIS (PA-601) FY2026	HMIS	N/A
Community Connections of Clearfield/Jefferson Counties	PA0459 Housing First	PSH	0
Community Services of Venango County, Inc.	PA0424 Sycamore Commons	PSH	0
Connect, Inc.	PA0904-DWEL	PSH	0
County of Butler	PA0290 Path Transition Age Project	PSH	0
County of Butler	PA0539 Home Again Butler County	PSH	0
County of Butler	PA0287 HOPE Project	PSH	0
County of Butler	PA0539 Home Again Butler County Expansion	PSH	0
County of Butler	Butler County Housing Support Program	SSO	N/A
Greene County Human Services	PA0780 Greene County Transitional Housing Project	TH	0
County of Washington	PA0291 - Permanent Supportive Housing	PSH	0
County of Washington	PA0296 - Shelter plus Care	PSH	0
County of Washington	PA0296 - Shelter plus Care Expansion	PSH	0
County of Washington	PA1048 Washington Transitional Project	TH	0

PA-601 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:	126
Number of Units w/Required Substance Use Treatment:	60
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	1 : 2.1

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
County of Washington	PA1150 - Washington County SWPA Transitional Housing	TH	0
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge	PSH	0
Crawford County Mental Health Awareness Program, Inc	PA0460 - CHAPS Family Housing	PSH	0
Crawford County Mental Health Awareness Program, Inc	PA0495 - Housing Now	PSH	0
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care	PSH	0
Crawford County Mental Health Awareness Program, Inc	PA1101 - Liberty House PSH	PSH	0
Crawford County Mental Health Awareness Program, Inc	PA1054-Open Doors	SSO	N/A
Crawford County Mental Health Awareness Program, Inc	PA1053-Connections	SSO	N/A
Crawford County Mental Health Awareness Program, Inc	PA1055-Passages	PSH	0
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge Expansion	PSH	0
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care Expansion	PSH	0
Crawford County Mental Health Awareness Program, Inc	CHAPS Horizons	SSO	N/A
Crisis Shelter of Lawrence County	Arise TH - Leasing	TH	0
Crisis Shelter of Lawrence County	PA1151 Arise DV PSH Project	PSH	0
Crisis Shelter of Lawrence County	PA0939-Arise TH Operating	TH	0
Fayette County Community Action Agency, Inc.	PA0616-Fayette Apartments	PSH	0
Fayette County Community Action Agency, Inc.	PA0560-Fairweather Lodge Supportive Housing	PSH	0
Fayette County Community Action Agency, Inc.	PA0846-FCCAA Transitional Housing Program	TH	0
Greene County Human Services	PA0651-Greene County Shelter Plus Care Project	PSH	0
Greene County Human Services	PA0538-Greene County Supportive Housing Project	PSH	0

PA-601 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:	126
Number of Units w/Required Substance Use Treatment:	60
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	1 : 2.1

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
Housing Authority of the County of Butler Inc.	PA0493 - Franklin Court Chronically Homeless	PSH	0
Indiana County Community Action Program, Inc.	PA0599 PHD Consolidated FY2026	PSH	0
Lawrence County Social Services	Foundations (SSO)	SSO	N/A
Lawrence County Social Services, Inc.	PA0304-NWRHA	PSH	0
Lawrence County Social Services, Inc.	PA0425-Turning Point	PSH	0
Lawrence County Social Services, Inc.	PA0314-SAFE		
Lawrence County Social Services, Inc.	PA0901-My First Place Youth Transitional Housing	TH	0
Lawrence County Social Services, Inc.	PA0775-TEAM Youth Transitional Housing	TH	0
Lawrence County Social Services, Inc.	PA-0718-Veterans Transitional Housing	TH	0
McKean County Redevelopment & Housing Authorities	PA0778- Northwest Transitional Housing	TH	0
Northern Cambria Community Development Corporation	PA0491 Chestnut Street Gardens PSH	PSH	0
Pennsylvania Coalition Against Domestic Violence	PA0980 - West CoC Regional DV RRH FY26 Renewal	RRH	0
Pennsylvania Coalition Against Domestic Violence	PA1149 FY26 New Western PA DV TH	TH	0
Pennsylvania Coalition Against Domestic Violence	PA1191 FY26 New Western PA DV TH - 2	TH	0
The Lighthouse Foundation	Lighthouse Foundation Transitional Housing	TH	20
Union Mission of Latrobe, Inc.	PA0540 - Union Mission Permanent Supportive Housing	PSH	0
Union Mission of Latrobe, Inc.	PA0940-DV Coordinated Entry Capacity	SSO-CE	N/A
Union Mission of Latrobe, Inc.	PA1099 - Western PA Coordinated Entry	SSO-CE	N/A
Victim Outreach Intervention Center	PA0280-VOICe-EnduringVOICe2026	PSH	0
Victim Outreach Intervention Center	PA0280-VOICe-Enduring VOICe Expansion	PSH	0
Warren-Forest EOC	PA0777 - Youngsville Permanent Supportive Housing	PSH	0

PA-601 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:	126
Number of Units w/Required Substance Use Treatment:	60
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	1 : 2.1

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
Warren-Forest EOC	PA0897 - Warren Permanent Supportive Housing	PSH	0
Warren-Forest EOC	Warren Forest EOC SSO Standalone	SSO	N/A
Westmoreland Community Action	PA0600 - WCA PSH	PSH	0
Westmoreland Community Action	PA1056 WCA Host Home	SSO	N/A
Westmoreland Community Action	PA1058 Westmoreland County Systems Navigation	SSO	N/A
Westmoreland Community Action	PA1059 YHDP WCA TH	TH	0
Westmoreland Community Action	PA1057 WCA Regional Systems Navigation	SSO	N/A
Westmoreland Community Action	Adult Regional TH - Recovery Focused	TH	20
Westmoreland Community Action	Adult Regional TH	TH	20

FY 2026

PA-601 Western Pennsylvania

Continuum of Care

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

Documents include the following:

- **Pages 2-4: Chart showing 100% of PA-601 TH, TH-RRH, PH-RRH & PH-PSH projects confirmed to require service participation**
- **Pages 5-**
 - **Service Participation Agreements for each project**
 - **The Service Participation Agreement for VSPs accounts for other federal regulatory requirements for VSPs**

PA-601 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:	56
Number of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	56
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?
Armstrong County Community Action of Pennsylvania	PA0274 - Armstrong County Permanent Supportive Housing Program	PSH	Yes
Armstrong County Community Action of Pennsylvania	PA0776 - Transitional Housing Program of Armstrong County	TH	Yes
Armstrong County Community Action of Pennsylvania	PA0716 - Family Transitional Housing Program of Armstrong County	TH	Yes
Cameron/Elk Counties Behavioral & Developmental Programs	PA0307-AHEAD	PSH	Yes
CAPSEA, Inc.	PA0311 Housing Plus	PSH	Yes
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care	PSH	Yes
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care Expansion	PSH	Yes
CAPSEA, Inc.	Housing Plus Pathways	TH	Yes
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons	PSH	Yes
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons Expansion	PSH	Yes
Community Connections of Clearfield/Jefferson Counties	PA0459 Housing First	PSH	Yes
Community Services of Venango County, Inc.	PA0424 Sycamore Commons	PSH	Yes
Connect, Inc.	PA0904-DWEL	PSH	Yes
County of Butler	PA0290 Path Transition Age Project	PSH	Yes
County of Butler	PA0539 Home Again Butler County	PSH	Yes
County of Butler	PA0287 HOPE Project	PSH	Yes
County of Butler	PA0539 Home Again Butler County Expansion	PSH	Yes
Greene County Human Services	PA0780 Greene County Transitional Housing Project	TH	Yes
County of Washington	PA0291 - Permanent Supportive Housing	PSH	Yes
County of Washington	PA0296 - Shelter plus Care	PSH	Yes
County of Washington	PA0296 - Shelter plus Care Expansion	PSH	Yes
County of Washington	PA1048 Washington Transitional Project	TH	Yes
County of Washington	PA1150 - Washington County SWPA Transitional Housing	TH	Yes

PA-601 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:	56
Number of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	56
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?
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge	PSH	Yes
Crawford County Mental Health Awareness Program, Inc	PA0460 - CHAPS Family Housing	PSH	Yes
Crawford County Mental Health Awareness Program, Inc	PA0495 - Housing Now	PSH	Yes
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care	PSH	Yes
Crawford County Mental Health Awareness Program, Inc	PA1101 - Liberty House PSH	PSH	Yes
Crawford County Mental Health Awareness Program, Inc	PA1055-Passages	PSH	Yes
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge Expansion	PSH	Yes
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care Expansion	PSH	Yes
Crisis Shelter of Lawrence County	Arise TH - Leasing	TH	Yes
Crisis Shelter of Lawrence County	PA1151 Arise DV PSH Project	PSH	Yes
Crisis Shelter of Lawrence County	PA0939-Arise TH Operating	TH	Yes
Fayette County Community Action Agency, Inc.	PA0616-Fayette Apartments	PSH	Yes
Fayette County Community Action Agency, Inc.	PA0560-Fairweather Lodge Supportive Housing	PSH	Yes
Fayette County Community Action Agency, Inc.	PA0846-FCCAA Transitional Housing Program	TH	Yes
Greene County Human Services	PA0651-Greene County Shelter Plus Care Project	PSH	Yes
Greene County Human Services	PA0538-Greene County Supportive Housing Project	PSH	Yes
Housing Authority of the County of Butler Inc.	PA0493 - Franklin Court Chronically Homeless	PSH	Yes
Indiana County Community Action Program, Inc.	PA0599 PHD Consolidated FY2026	PSH	Yes
Lawrence County Social Services, Inc.	PA0304-NWRHA	PSH	Yes

PA-601 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:	56
Number of TH, TH-RRH, PH-RRH, PH-PSH Projects w/Service Participation Requirements:	56
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?
Lawrence County Social Services, Inc.	PA0425-Turning Point	PSH	Yes
Lawrence County Social Services, Inc.	PA0901-My First Place Youth Transitional Housing	TH	Yes
Lawrence County Social Services, Inc.	PA0775-TEAM Youth Transitional Housing	TH	Yes
Lawrence County Social Services, Inc.	PA-0718-Veterans Transitional Housing	TH	Yes
McKean County Redevelopment & Housing Authorities	PA0778- Northwest Transitional Housing	TH	Yes
Northern Cambria Community Development Corporation	PA0491 Chestnut Street Gardens PSH	PSH	Yes
Pennsylvania Coalition Against Domestic Violence	PA0980 - West CoC Regional DV RRH FY26 Renewal	RRH	Yes
Pennsylvania Coalition Against Domestic Violence	PA1149 FY26 New Western PA DV TH	TH	Yes
Pennsylvania Coalition Against Domestic Violence	PA1191 FY26 New Western PA DV TH - 2	TH	Yes
The Lighthouse Foundation	Lighthouse Foundation Transitional Housing	TH	Yes
Union Mission of Latrobe, Inc.	PA0540 - Union Mission Permanent Supportive Housing	PSH	Yes
Victim Outreach Intervention Center	PA0280-VOICe-EnduringVOICe2026	PSH	Yes
Victim Outreach Intervention Center	PA0280-VOICe-Enduring VOICe Expansion	PSH	Yes
Warren-Forest EOC	PA0777 - Youngsville Permanent Supportive Housing	PSH	Yes
Warren-Forest EOC	PA0897 - Warren Permanent Supportive Housing	PSH	Yes
Westmoreland Community Action	PA0600 - WCA PSH	PSH	Yes
Westmoreland Community Action	PA1059 YHDP WCA TH	TH	Yes
Westmoreland Community Action	Adult Regional TH - Recovery Focused	TH	Yes
Westmoreland Community Action	Adult Regional TH	TH	Yes

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Transitional Housing Master Leasing Project

Welcome to Arise's Transitional Housing Master Leasing Project. This program provides safe, confidential, scattered-site transitional housing and supportive services to survivor households with minor children who are experiencing homelessness or fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, human trafficking, or other forms of interpersonal violence.

Arise provides supportive services using a survivor-centered, trauma-informed, and housing-focused approach. Services are intended to support safety, housing stability, economic stability, wellness, and transition to permanent housing.

Supportive services are voluntary. Participants may choose which services and resources they would like to receive based on their individual needs, preferences, and goals.

Supportive Services Available

Arise offers or coordinates the following supportive services:

- ☐ **Housing Advocacy and Case Management:** Individualized support to identify housing barriers, develop goals, connect with resources, and address needs that may affect housing stability.
- ☐ **Housing Navigation:** Assistance searching for permanent housing, completing housing applications, identifying housing opportunities, communicating with landlords, and preparing for transition from transitional housing.
- ☐ **Safety Planning:** Individualized safety planning and connections to resources to address current or ongoing safety concerns.
- ☐ **Financial Empowerment:** Assistance with budgeting, financial planning, financial stability, and addressing barriers to economic independence.

☐ **Employment and Income Support:** Assistance with employment, job search, education, job training, and identifying income opportunities when appropriate.

☐ **Benefits Assistance:** Assistance accessing mainstream benefits and public resources, including SNAP, Medicaid, Medicare, SSI/SSDI, TANF, and other eligible benefits.

☐ **Childcare Assistance:** Assistance with eligible childcare costs, including childcare tuition or copay assistance, to help reduce barriers to employment, education, and family stability. Assistance is subject to program eligibility and available funding.

☐ **Transportation Assistance:** Assistance with transportation costs and connections to transportation resources for housing, employment, childcare, healthcare, legal services, and other essential needs. Assistance is subject to program limits and available funding.

☐ **Utility Assistance:** Assistance with eligible utility deposits or other utility-related housing stabilization needs, subject to program eligibility and available funding.

☐ **Food Assistance:** Assistance with food needs and connections to food resources to support household stability. Assistance is subject to program limits and available funding.

☐ **Trauma-Informed Counseling:** Voluntary supportive counseling focused on healing, coping skills, resilience, and emotional well-being.

☐ **Family Support:** Family-focused services, including Window Between Worlds programming, to support healing and caregiver-child connections.

☐ **Legal Services:** Access to Arise's Legal Advocacy Program and Civil Legal Representation Program, including legal advocacy, court support, safety planning, and civil legal assistance when eligible.

☐ **Community Resource Connections:** Referrals and connections to healthcare, behavioral health, childcare, transportation, food assistance, substance use services, education, workforce programs, and other community resources.

☐ **Transition Planning:** Assistance preparing for permanent housing and connecting to ongoing services and resources before program exit.

Participant Choice and Engagement

As a participant, I understand that supportive services are voluntary. I may choose to:

- ☐ Meet or communicate with my Housing Advocate when I would like assistance.
- ☐ Work with staff to identify housing, safety, financial, employment, or other goals.
- ☐ Develop or update an individualized service or housing stability plan if I choose to participate in case management.
- ☐ Accept or decline supportive services and referrals based on my needs and preferences.
- ☐ Request assistance with transportation, childcare, food, utility deposits, or other available resources when needed.
- ☐ Ask staff for assistance when I need help accessing resources or addressing housing-related concerns.
- ☐ Participate in activities that support my individual goals, such as housing search, employment, education, counseling, healthcare, legal services, or benefits applications.

Engagement Goal

Participants are encouraged to engage in approximately **20 hours per week** of services, activities, employment, education, or other goal-related activities when appropriate to their individual circumstances. Engagement may look different for each participant and may change based on individual needs, family responsibilities, safety concerns, and circumstances.

Acknowledgment

By signing below, I acknowledge that:

- ☐ I have received information about the supportive services available through the program.
- ☐ I understand that supportive services are voluntary and that I may accept or decline services and referrals.
- ☐ I understand that some forms of financial assistance, including childcare, transportation, food, and utility assistance, may have eligibility requirements, limits, and funding availability.
- ☐ I understand that the 20-hour weekly engagement goal is encouraged but is not a mandatory supportive-service requirement.

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Permanent Supportive Housing Project

Welcome to **Arise's Permanent Supportive Housing Program**. This program provides safe, stable, and confidential permanent housing and supportive services to survivor households who have chronically experienced homelessness with a HUD recognized disability and may have experienced domestic violence, dating violence, sexual assault, stalking, human trafficking, or other forms of interpersonal violence.

Arise provides supportive services using a **survivor-centered, trauma-informed, and housing-focused approach**. Services are individualized based on each participant's needs, preferences, strengths, safety concerns, and goals and are intended to support long-term housing stability, safety, wellness, economic stability, and independence.

Supportive services are voluntary. Participants may choose which services and resources they would like to receive based on their individual needs, preferences, and goals. Participation in supportive services is not a condition of receiving or maintaining housing assistance.

SUPPORTIVE SERVICES AVAILABLE

Arise offers or coordinates the following supportive services:

- ☐ **Housing Advocacy and Case Management:** Individualized support to identify housing barriers, develop goals, connect with resources, and address needs that may affect housing stability.
- ☐ **Housing Stability Support:** Assistance addressing concerns that may affect continued housing stability, including lease compliance, communication with landlords or property management, household needs, and other housing-related concerns.
- ☐ **Safety Planning:** Individualized safety planning and connections to resources to address current or ongoing safety concerns.
- ☐ **Financial Empowerment:** Assistance with budgeting, financial planning, financial stability, and addressing barriers to economic independence.

- ☐ **Employment and Income Support:** Assistance with employment, job search, education, job training, and identifying income opportunities when appropriate.
- ☐ **Benefits Assistance:** Assistance accessing mainstream benefits and public resources, including SNAP, Medicaid, Medicare, SSI/SSDI, TANF, and other eligible benefits.
- ☐ **Disability Support and Connections:** Assistance identifying and accessing resources related to a participant's disability, including disability-related benefits, healthcare, supportive services, accessibility resources, and community-based supports. Staff may assist participants with identifying appropriate resources and making connections based on individual needs and preferences.
- ☐ **Food Assistance:** Assistance for food needs with connections to food resources to support household stability. Assistance is subject to program limits and available funding.
- ☐ **Trauma-Informed Counseling:** Voluntary supportive counseling focused on healing, coping skills, resilience, and emotional well-being.
- ☐ **Family Support:** Family-focused services, including Window Between Worlds programming, to support healing and caregiver-child connections.
- ☐ **Legal Services:** Access to Arise's Legal Advocacy Program and Civil Legal Representation Program, including legal advocacy, court support, safety planning, and civil legal assistance when eligible.
- ☐ **Community Resource Connections:** Referrals and connections to healthcare, behavioral health, childcare, transportation, food assistance, substance use services, education, workforce programs, and other community resources.
- ☐ **Ongoing Housing Stability and Goal Planning:** Assistance identifying and working toward individual goals related to housing stability, wellness, financial stability, employment, education, family well-being, and other areas identified by the participant.
- ☐ **Utility Assistance:** Assistance may be available to eligible households whose rental calculation awards them a utility reimbursement.

Services and financial assistance may be provided through the Permanent Supportive Housing Program, other Arise programs, or community partners. Availability may depend on individual eligibility, program requirements, funding availability, and participant needs.

PARTICIPANT CHOICE AND ENGAGEMENT

As a participant, I understand that supportive services are voluntary. I may choose to:

- ☐ Meet or communicate with my Housing Advocate or Case Manager when I would like assistance.
- ☐ Work with staff to identify housing, safety, financial, employment, disability-related, wellness, or other goals.
- ☐ Develop or update an individualized service or housing stability plan if I choose to participate in case management.
- ☐ Accept or decline supportive services and referrals based on my needs and preferences.
- ☐ Request assistance with transportation, childcare, food, housing stability, utility assistance, disability-related resources, or other available resources when needed.
- ☐ Ask staff for assistance when I need help accessing resources or addressing housing-related concerns.
- ☐ Participate in activities that support my individual goals, such as employment, education, counseling, healthcare, legal services, benefits applications, disability-related services, or other activities that support my long-term stability.

ACCESSIBILITY AND REASONABLE ACCOMMODATIONS

If I have a disability or other accessibility need that makes it difficult for me to participate in services or activities, I may request a reasonable accommodation.

An accommodation may include a change in how services are provided, a different meeting format or location, assistance with communication, or another appropriate support.

Program staff will explain the process for requesting a reasonable accommodation and will work with me through Arise's reasonable accommodation process.

RE-ENGAGEMENT AND CONTINUED SUPPORT

If I stop engaging in supportive services or have difficulty participating in scheduled activities, program staff will make reasonable efforts to contact me and understand what may be making engagement difficult.

Staff may offer different meeting options, additional support, referrals, changes to my service or housing stability plan, or other reasonable steps to help me re-engage.

Failure to engage in supportive services will not result in termination from the program or loss of housing assistance. Program staff will continue to work with me to identify services, activities, and supports that are appropriate to my circumstances and individual goals.

ACKNOWLEDGMENT

By signing below, I acknowledge that:

- ☐ I have received information about the supportive services available through the program and additional resources that may be available through other Arise programs or community partners.
- ☐ I understand that supportive services are voluntary and that I may accept or decline services and referrals.
- ☐ I understand that participation in supportive services is not a condition of receiving or maintaining housing assistance.
- ☐ I understand that some forms of financial assistance, including childcare, transportation, food, and utility assistance, may have eligibility requirements, limits, and funding availability.
- ☐ I understand that services and resources provided through other Arise programs or community partners may have separate eligibility requirements and funding limitations.
- ☐ I understand that disability-related services and resources are voluntary and may include assistance connecting to benefits, healthcare, supportive services, accessibility resources, and other community-based supports.

☐ I understand that I may request a reasonable accommodation if I have a disability or accessibility need that affects my ability to participate.

☐ I understand that failure to engage in supportive services will not result in termination from the program or loss of housing assistance.

☐ I understand that program staff are available to assist me with housing stability, safety, wellness, disability-related needs, and my individual goals.

☐ I have had an opportunity to ask questions about this agreement and the supportive services available to me.

Participant Name: _____

Participant Signature: _____

Date: _____

Staff Name: _____

Staff Signature: _____

Date: _____

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **the Armstrong County 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.

The Armstrong County 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 **the Armstrong County 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.

The Armstrong County Permanent Supportive Housing Program provides the following supportive services to help participants obtain and retain permanent housing:

- **Personalized Case Management:** One-on-one working relationships with a dedicated case manager to develop, monitor, and update an individualized housing stability plan tailored to the client's goals.
- **Employment & Income Assistance:** Counseling, job-seeking assistance, and skills connections designed to help clients secure employment, increase household income, and achieve long-term economic self-sufficiency.
- **Connection to Mainstream Resources:** Direct routing and assistance with enrolling in community health services, public benefits, transportation programs, and local food assistance.

- Short-Term Rental & Utility Assistance: Financial support with rent aligned with regional standards to help participants maintain stable living conditions while transitioning into permanent housing.

As a participant in **the Armstrong County Permanent Supportive Housing 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 Projects Requiring Substance Use Treatment

The Armstrong County Permanent Supportive Housing Program is a treatment-focused program that requires all participants to engage in substance use treatment. As a participant in **the Armstrong County Permanent Supportive Housing Program** 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.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **the Armstrong County Permanent Supportive Housing 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, **the Armstrong County 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

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Family Transitional Housing Program of Armstrong County**. 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.

Family Transitional Housing Program of Armstrong County 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 **Family Transitional Housing Program of Armstrong County** 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.

Family Transitional Housing Program of Armstrong County provides the following supportive services to help participants obtain and retain permanent housing:

- **Personalized Case Management:** One-on-one working relationships with a dedicated case manager to develop, monitor, and update an individualized housing stability plan tailored to the client's goals.
- **Employment & Income Assistance:** Counseling, job-seeking assistance, and skills connections designed to help clients secure employment, increase household income, and achieve long-term economic self-sufficiency.
- **Connection to Mainstream Resources:** Direct routing and assistance with enrolling in community health services, public benefits, transportation programs, and local food assistance.

- Short-Term Rental & Utility Assistance: Financial support with rent aligned with regional standards to help participants maintain stable living conditions while transitioning into permanent housing.

As a participant in **Family Transitional Housing Program of Armstrong County**, 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.

For Projects Requiring Substance Use Treatment

Family Transitional Housing Program of Armstrong County is a treatment-focused program that requires all participants to engage in substance use treatment. As a participant in **Family Transitional Housing Program of Armstrong County** 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.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Family Transitional Housing Program of Armstrong County** 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, **Family Transitional Housing Program of Armstrong County** 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.

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the **Transitional Housing Program of Armstrong County**. 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.

Transitional Housing Program of Armstrong County 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 Program of Armstrong County** 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.

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

- **Personalized Case Management:** One-on-one working relationships with a dedicated case manager to develop, monitor, and update an individualized housing stability plan tailored to the client's goals.
- **Employment & Income Assistance:** Counseling, job-seeking assistance, and skills connections designed to help clients secure employment, increase household income, and achieve long-term economic self-sufficiency.
- **Connection to Mainstream Resources:** Direct routing and assistance with enrolling in community health services, public benefits, transportation programs, and local food assistance.

- Short-Term Rental & Utility Assistance: Financial support with rent aligned with regional standards to help participants maintain stable living conditions while transitioning into permanent housing.

As a participant in **Transitional Housing Program of Armstrong County**, 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.

For Projects Requiring Substance Use Treatment

Transitional Housing Program of Armstrong County is a treatment-focused program that requires all participants to engage in substance use treatment. As a participant in the **Transitional Housing Program of Armstrong County** 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.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Transitional Housing Program of Armstrong County** 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, **Transitional Housing Program of Armstrong County** 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.

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **AHEAD**. 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.

AHEAD 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 **AHEAD** 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.

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

- **Blended Case Management**
- **Outpatient Psychiatric Services**
- **Outpatient Mental Health Therapy**
- **Psychiatric Rehab Services (Site based and Mobile)**
- **PATH Caseworker**
- **Forensic Caseworker**
- **On Site access to Substance Use Treatment**

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

- ☐ Meet or communicate with my assigned case manager at least **once a month**.
- ☐ 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 **AHEAD** 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, **AHEAD** 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.

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Housing Plus Program. 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.

CAPSEA, Inc. 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 the Housing Plus Program 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 goal plans.

CAPSEA, Inc. provides the following supportive services to help participants obtain and retain permanent housing. As a participant in the Housing Plus Program, 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 the Housing Plus Program 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, CAPSEA, Inc. and the Housing Plus Program coordinator will work with me to either increase engagement or find a housing option that better meets my needs.

By signing below, I acknowledge that I have read this agreement thoroughly and agree to the terms of said agreement.

Participant signature

CAPSEA Housing Case Manager Signature

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Shelter Plus Care Program. 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.

CAPSEA, Inc. 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 the Shelter Plus Care Program 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 goal plans.

CAPSEA, Inc. provides the following supportive services to help participants obtain and retain permanent housing. As a participant in the Housing Plus Program, 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 the Shelter Plus Care Program 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, CAPSEA, Inc. and the Shelter Plus Care Program coordinator will work with me to either increase engagement or find a housing option that better meets my needs.

By signing below, I acknowledge that I have read this agreement thoroughly and agree to the terms of said agreement.

Participant signature

CAPSEA Housing Case Manager Signature

CLARION COUNTY HOUSING AUTHORITY
PA0310 Housing for Homeless and Disabled Persons
SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to PA0310 Housing for Homeless and Disabled Persons. 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.

PA0310 Housing for Homeless and Disabled Persons 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 PA0310 Housing for Homeless and Disabled Persons 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).

PA0310 Housing for Homeless and Disabled Persons provides the following supportive services to help participants obtain and retain permanent housing:

- ☐ Monthly Case Management with PSH Manager
- ☐ Referrals/Correspondence to Family Psychological Associates
- ☐ Referrals/Correspondence to LIFE-NWPA (those over the age of 55)
- ☐ Referrals/Correspondence to Clarion County Housing Authority
- ☐ Assist with Housing Applications
- ☐ Communication with Probation/Parole (as needed for those assigned)
- ☐ Connect to Food Resources
- ☐ Connect to Transportation needs (busing, taxi, other agencies)
- ☐ Referrals/Correspondence to CCR Drop-In Center (those with a mental health diagnosis)
- ☐ Assist with paperwork needed for Emotional Support Animals
- ☐ Referrals/Correspondence to CYS (for those with children)
- ☐ Referrals/Correspondence to WIC (for those pregnant and/or with children)
- ☐ Referrals/Correspondence to Clarion Drug & Alcohol Commission
- ☐ Connect to Volunteer/Community Service Agencies
- ☐ Referrals/Correspondence to Social Security Administration
- ☐ Assist with documentation (photo ID, drivers license, social security card, birth certificate)
- ☐ Correspondence with Local/State Police

- ☐ Referrals/Correspondence with Employment/Career Agencies
- ☐ Referrals/Correspondence with area Veteran programs
- ☐ Referrals/Correspondence to Summit Legal Aid (for any Fair Housing Laws)
- ☐ Connect to Area School Districts (for those with children)
- ☐ Connect to Local/Online College Programs
- ☐ Communication between Property Management, Tenant, Maintenance, and PSH Manager (caseworker)
- ☐ Referrals/Correspondence to Employers
- ☐ Referrals/Correspondence to the County Assistance Office
- ☐ Referrals/Correspondence to Medical Needs
- ☐ Referrals to the YMCA (health & wellness, food, clothing)
- ☐ Referrals to Clarion Shelter Task Force
- ☐ Referrals to Housing Problem Solving

As a participant in PA0310 Housing for Homeless and Disabled Persons, I agree to:

- ☐ Meet or communicate with my assigned case manager at least once a month (more if necessary).
- ☐ 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.

If I have a disability that makes it difficult for me to meet PA0310 Housing for Homeless and Disabled Persons 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 other 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, PA0310 Housing for Homeless and Disabled Persons 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

Community Connections of Clearfield/Jefferson Counties

PSH-Housing First Program

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Community Connections of Clearfield/Jefferson Counties-Permanent Supportive Housing First 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.

Community Connections of Clearfield/Jefferson Counties-Permanent Supportive Housing First 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 Community Connections of Clearfield/Jefferson Counties-Permanent Supportive Housing First 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).

Community Connections of Clearfield/Jefferson Counties-Permanent Supportive Housing First Program provides the following supportive services to help participants obtain and retain permanent housing:

- Develop a personalized Housing and Service plan that is person centered, tailored to the participant's needs
- Assisting with housing search for enrolled individuals and housing navigation
- Assisting participants with housing placement
- Maintain landlord engagement
- Assisting with housing stabilization
- Connection to Mainstream Benefits
- Assisting with replacements of identification and personal documents
- Connection to Community Resources
- Ongoing Support to maintain Permanent Housing
- Case Management services
- Referrals for Substance abuse treatment centers
- Referrals for Healthcare and Behavioral Health Referrals
- Referrals for Peer Support Services

- Crisis Intervention services
- Others referrals as participant needs
- Assist with transportation referrals and/or obtaining bus passes

As a participant in Community Connections of Clearfield/Jefferson Counties-Permanent Supportive Housing First Program, I agree to:

- Meet or communicate with my assigned case manager at least once monthly or more depending on the need of the participant.
- 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 Community Connections of Clearfield/Jefferson Counties-Permanent Supportive Housing First 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, Community Connections of Clearfield/Jefferson Counties-Permanent Supportive Housing First 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 **Sycamore Commons**. 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.

Sycamore Commons 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 **Sycamore Commons** 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.

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

- Provides on-site case management as needed for all tenants.
- Connects tenants to resources such as health care, mental health assistance, substance use treatment, and employment training as needed.
- Provides opportunities for volunteering and increasing social independence.
- Offer support and tools as needed for access and support.

As a participant in **Sycamore Commons**, 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 **Sycamore Commons** 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, **Sycamore Commons** 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 **SPHS Connect Inc.** 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.

SPHS Connect, Inc. 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 **SPHS Connect, Inc.** 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).

SPHS Connect, Inc. provides the following supportive services to help participants obtain and retain permanent housing:

- **Annual assessment of service needs:** Evaluating participant requirements over time.
- **Assistance with moving costs:** Paying for truck rentals or security deposits.
- **Case management:** Connecting participants to tailored guidance and local systems.
- **Child care:** Funding care so parents can work or attend school.
- **Education services:** Providing literacy, GED, or schooling assistance.
- **Employment assistance and job training:** Offering vocational programs and job placement.
- **Food assistance:** Providing meals or nutritional support.
- **Housing search and counseling services:** Helping clients find landlords and units.
- **Legal services:** Assisting with housing stability or civil legal needs.
- **Life skills training:** Teaching budgeting, cooking, and household management.
- **Mental health services:** Providing counseling and psychiatric referrals.
- **Outpatient health services:** Supporting routine medical and clinical care.
- **Substance abuse treatment services:** Providing recovery and clinical treatment programs.
- **Transportation:** Paying for bus passes or travel to appointments.
- **Utility deposits:** Helping with setup costs for home utilities

As a participant in **SPHS Connect, Inc.**, 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 **SPHS Connect, Inc.** 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, **SPHS Connect, Inc.** 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

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **SPHS Connect Inc.** 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.

SPHS Connect, Inc. 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 **SPHS Connect, Inc.** 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).

SPHS Connect, Inc. provides the following supportive services to help participants obtain and retain permanent housing:

- **Annual assessment of service needs:** Evaluating participant requirements over time.
- **Assistance with moving costs:** Paying for truck rentals or security deposits.
- **Case management:** Connecting participants to tailored guidance and local systems.
- **Child care:** Funding care so parents can work or attend school.
- **Education services:** Providing literacy, GED, or schooling assistance.
- **Employment assistance and job training:** Offering vocational programs and job placement.
- **Food assistance:** Providing meals or nutritional support.
- **Housing search and counseling services:** Helping clients find landlords and units.
- **Legal services:** Assisting with housing stability or civil legal needs.
- **Life skills training:** Teaching budgeting, cooking, and household management.
- **Mental health services:** Providing counseling and psychiatric referrals.
- **Outpatient health services:** Supporting routine medical and clinical care.
- **Substance abuse treatment services:** Providing recovery and clinical treatment programs.
- **Transportation:** Paying for bus passes or travel to appointments.
- **Utility deposits:** Helping with setup costs for home utilities

As a participant in **SPHS Connect, Inc.**, 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 **SPHS Connect, Inc.** 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, **SPHS Connect, Inc.** 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

COC SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Home Again Butler County. This agreement explains the supportive services available to you and the expectations while you participate in the program. These services are here to help you keep safe, stable housing and work toward your personal goals.

Home Again Butler County is funded by the U.S. Department of Housing and Urban Development (HUD) through the Continuum of Care (CoC) Program. Federal regulations (24 CFR 578.75) require participants to take part in supportive services that help them maintain housing. Your service requirements are based on your strengths, needs, and goals that you discuss with your case manager in your Individualized Service Plan (ISP).

Supportive Services Provided

All participants receive supportive services to help them stay housed and increase independence. You will work with a case manager to create a Housing Stability Plan and meet or talk regularly to review progress.

Services may include:

- Case management
- Help with job searching, job training, or education
- Life-skills support (budgeting, communication, home care)
- Connections to community partners for mental health, substance use treatment, financial counseling, parenting supports, and school-related needs for children

Staff use a “progressive engagement” approach, meaning they start with basic support and add more help if you need it.

Your Responsibilities as a Participant

By being part of Home Again Butler County, you agree to:

- ☐ Meet or communicate with your case manager at least once a month
- ☐ Participate in case management and service planning to support housing stability
- ☐ Help create and update your Individualized Service Plan and Housing Stability Plan
- ☐ Work with your case manager to pursue employment and/or benefits that support your housing
- ☐ Tell staff about major changes affecting your housing, income, household, health, or ability to participate
- ☐ Let staff know if you cannot attend a meeting and reschedule

Reasonable Accommodation

If you have a disability that makes it hard to meet service requirements, you may request reasonable accommodation. This might include changing how meetings happen, where they happen, how communication is provided, or adjusting parts of your service plan. Staff will explain the process and help you with the request.

If Participation Becomes Difficult

If you stop participating in services, staff will contact you to understand what is making things difficult and offer support. They may suggest different meeting times, phone or virtual meetings, referrals, or changes to your service plan to help you stay involved.

Not participating does not automatically result in losing your housing or being removed from the program. If participation problems continue after staff try several ways to help, the program may take additional steps, such as a warning, a corrective plan, or a review meeting.

Termination is only considered in serious or ongoing situations. You will receive written notice of any action and have the chance to respond or appeal.

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 **Shelter + Care 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.

Shelter + Care 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 Shelter + Care 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).

Shelter + Care provides the following supportive services to help participants obtain and retain permanent housing:

☐ **Housing Case Management:** Case management services emphasize engagement and problem-solving over therapeutic goals and development of service plans are participant-driven without predetermined goals. MH Caseworker will assist in linking Participants to services. This may include Blended Case Managers, Outpatient Therapy, Partial Programs, or other services as determined by the Participant.

As a participant in **Shelter + Care**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least 2 times a month.
- ☐ 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 **Shelter + Care** services 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, **Shelter + Care** 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

COC SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the Path Transition Age Project. This agreement explains the supportive services available to you and the expectations while you participate in the program. These services are here to help you keep safe, stable housing and work toward your personal goals.

The Path Transition Age Project is funded by the U.S. Department of Housing and Urban Development (HUD) through the Continuum of Care (CoC) Program. Federal regulations (24 CFR 578.75) require participants to take part in supportive services that help them maintain housing. Your service requirements are based on your strengths, needs, and goals that you discuss with your case manager in your Individualized Service Plan (ISP).

Supportive Services Provided

All participants receive supportive services to help them stay housed and increase independence. You will work with a case manager to create a Housing Stability Plan and meet or talk regularly to review progress.

Services may include:

- Case management
- Help with job searching, job training, or education
- Life-skills support (budgeting, communication, home care)
- Connections to community partners for mental health, substance use treatment, financial counseling, parenting supports, and school-related needs for children

Staff use a “progressive engagement” approach, meaning they start with basic support and add more help if you need it.

Your Responsibilities as a Participant

By being part of the Path Transition Age Project , you agree to:

- ☐ Meet or communicate with your case manager at least once a month
- ☐ Participate in case management and service planning to support housing stability
- ☐ Help create and update your Individualized Service Plan and Housing Stability Plan
- ☐ Work with your case manager to pursue employment and/or benefits that support your housing
- ☐ Tell staff about major changes affecting your housing, income, household, health, or ability to participate
- ☐ Let staff know if you cannot attend a meeting and reschedule

Reasonable Accommodation

If you have a disability that makes it hard to meet service requirements, you may request reasonable accommodation. This might include changing how meetings happen, where they happen, how communication is provided, or adjusting parts of your service plan. Staff will explain the process and help you with the request.

If Participation Becomes Difficult

If you stop participating in services, staff will contact you to understand what is making things difficult and offer support. They may suggest different meeting times, phone or virtual meetings, referrals, or changes to your service plan to help you stay involved.

Not participating does not automatically result in losing your housing or being removed from the program. If participation problems continue after staff try several ways to help, the program may take additional steps, such as a warning, a corrective plan, or a review meeting.

Termination is only considered in serious or ongoing situations. You will receive written notice of any action and have the chance to respond or appeal.

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

COC SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to the HOPE Project . This agreement explains the supportive services available to you and the expectations while you participate in the program. These services are here to help you keep safe, stable housing and work toward your personal goals.

The HOPE Project is funded by the U.S. Department of Housing and Urban Development (HUD) through the Continuum of Care (CoC) Program. Federal regulations (24 CFR 578.75) require participants to take part in supportive services that help them maintain housing. Your service requirements are based on your strengths, needs, and goals that you discuss with your case manager in your Individualized Service Plan (ISP).

Supportive Services Provided

All participants receive supportive services to help them stay housed and increase independence. You will work with a case manager to create a Housing Stability Plan and meet or talk regularly to review progress.

Services may include:

- Case management
- Help with job searching, job training, or education
- Life-skills support (budgeting, communication, home care)
- Connections to community partners for mental health, substance use treatment, financial counseling, parenting supports, and school-related needs for children

Staff use a “progressive engagement” approach, meaning they start with basic support and add more help if you need it.

Your Responsibilities as a Participant

By being part of the HOPE Project, you agree to:

- ☐ Meet or communicate with your case manager at least once a month
- ☐ Participate in case management and service planning to support housing stability
- ☐ Help create and update your Individualized Service Plan and Housing Stability Plan
- ☐ Work with your case manager to pursue employment and/or benefits that support your housing
- ☐ Tell staff about major changes affecting your housing, income, household, health, or ability to participate
- ☐ Let staff know if you cannot attend a meeting and reschedule

Reasonable Accommodation

If you have a disability that makes it hard to meet service requirements, you may request reasonable accommodation. This might include changing how meetings happen, where they happen, how communication is provided, or adjusting parts of your service plan. Staff will explain the process and help you with the request.

If Participation Becomes Difficult

If you stop participating in services, staff will contact you to understand what is making things difficult and offer support. They may suggest different meeting times, phone or virtual meetings, referrals, or changes to your service plan to help you stay involved.

Not participating does not automatically result in losing your housing or being removed from the program. If participation problems continue after staff try several ways to help, the program may take additional steps, such as a warning, a corrective plan, or a review meeting.

Termination is only considered in serious or ongoing situations. You will receive written notice of any action and have the chance to respond or appeal.

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

CHAPS SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Participant Name: _____

Supportive Housing Program: (select one)

☐ Liberty House ☐ Shelter Plus Care ☐ Family Housing ☐ Housing Now ☐ FW Lodge ☐ Passages

Welcome to **CHAPS 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.

The 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), participants in **the 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 Goal Plan.

CHAPS Supportive Housing Program provides the following supportive services to assist participants in obtaining and maintaining permanent housing, promoting housing stability, and increasing independence:

☐ **Housing Stability and Independence:** The program provides an affordable housing opportunity for individuals who benefit from a supportive living environment. Services are designed to promote housing stability, strengthen independent living skills, and support participants in achieving greater self-sufficiency and independence.

☐ **Individualized Case Management:** Case workers provide consistent, structured, and individualized support to assist participants with maintaining housing, developing independent living skills, strengthening connections within the community, and identifying and achieving personal goals.

☐ **Comprehensive Support Services:** Services may include participant-centered goal planning, annual assessments of service needs, tenancy supports, problem-solving, budgeting and household management assistance, connection to mainstream benefits and resources, coordination with healthcare and behavioral health providers, and linkage to appropriate community-based services. Meaningful service participation may include independent living skills development, healthcare and behavioral health appointments, employment-related activities, recovery supports, peer support, community integration, and other services that promote housing stability and self-sufficiency.

☐ **Community-Based Service Engagement:** Participant engagement may include case management, independent living skills development, Mobile Psychiatric Rehabilitation, Certified Peer Support, Journey

Center Clubhouse activities, support groups, healthcare and behavioral health appointments, substance use recovery supports, employment activities, PA CareerLink services, education or vocational training, and other appropriate community-based activities that support individual goals and housing stability.

☐ **Participant-Centered Approach:** The project emphasizes meaningful engagement and individualized support rather than a one-size-fits-all approach. When appropriate, case workers will work collaboratively with participants to develop weekly service schedules that align with their identified goals, needs, preferences, and priorities. Participant progress may be documented through case notes, referrals, and updates to individual goal plans. This approach ensures that participants receive the appropriate level and type of support needed to successfully maintain housing while promoting personal choice, autonomy, and independence.

As a participant in **CHAPS Supportive Housing Program**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **biweekly**.
- ☐ 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 Goal Plan.
- ☐ Work with program staff to develop and pursue Move-On strategies, which could include private housing or other subsidized housing.
- ☐ 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 **CHAPS 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.

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, **CHAPS** 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 Fayette County Community Action Agency's (FCCAA) Permanent Supportive Housing Program (PSH) Fayette Apartments Program (FA). 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.

FA 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 FA 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.

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

FA will provide participant-centered supportive housing services designed to promote housing stability, self-sufficiency, and long-term success in permanent housing. Services may include housing search and placement assistance, landlord liaison and mediation, lease education, eviction prevention, and ongoing housing retention support. Participants will be offered regular case management, including needs assessments, individualized service planning, goal setting, crisis intervention, and referrals to community resources. Additional supportive services may include assistance accessing employment and educational opportunities, public benefits, healthcare, mental health services, substance use treatment, financial literacy education, budgeting assistance, life skills development, transportation resources, and other services necessary to support independent living. The Program will coordinate with community partners and service providers to ensure participants

have access to the resources and supports needed to maintain permanent housing and improve overall quality of life. Participation in supportive services is encouraged and tailored to the unique needs, goals, and preferences of each household.

As a participant in FA, 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 FA 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, FA 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 Fayette County Community Action Agency's (FCCAA) Permanent Supportive Housing Program (PSH) Fairweather Lodge Supportive Housing Program (FWL). 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.

FWL 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 FWL 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.

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

FWL will provide participant-centered supportive housing services designed to promote housing stability, self-sufficiency, and long-term success in permanent housing. Services may include housing search and placement assistance, landlord liaison and mediation, lease education, eviction prevention, and ongoing housing retention support. Participants will be offered regular case management, including needs assessments, individualized service planning, goal setting, crisis intervention, and referrals to community resources. Additional supportive services may include assistance accessing employment and educational opportunities, public benefits, healthcare, mental health services, substance use treatment, financial literacy education, budgeting assistance, life skills development, transportation resources, and other services necessary to support independent living. The Program will coordinate with community partners and service providers to ensure participants

have access to the resources and supports needed to maintain permanent housing and improve overall quality of life. Participation in supportive services is encouraged and tailored to the unique needs, goals, and preferences of each household.

As a participant in FWL, 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 FWL 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, FWL 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 FCCAA 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.

FCCAA 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 FCCAA 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.

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

- FCCAA Transitional Housing Program provides the following supportive services to help participants obtain and retain permanent housing: comprehensive case management; housing stabilization and individualized service planning; assistance with locating and securing permanent housing; landlord mediation and advocacy; budgeting and financial literacy education; employment readiness assistance, including job search, resume development, and referral to workforce programs; benefits screening and assistance with applications for public benefits; life skills education; transportation assistance related to housing, employment, and essential services; referrals to physical health, behavioral health, and substance use treatment providers; crisis intervention and problem-solving support; assistance obtaining identification and other vital documents; connection to community

resources; and ongoing follow-up services designed to promote self-sufficiency, housing stability, and successful transition to permanent housing.

As a participant in FCCAA Transitional Housing 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.

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 FCCAA Transitional Housing 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, FCCAA 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

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Franklin Court Chronically Homeless 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.

Franklin Court Chronically Homeless 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 **Franklin Court Chronically Homeless 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.

Franklin Court Chronically Homeless Program provides the following supportive services to help participants obtain and retain permanent housing:

- One-on-one case management.
- A personalized housing stability and action plan.
- Assistance obtaining and maintaining safe and affordable housing.
- Housing stability and tenancy support.
- Benefits and entitlement assistance.
- Transportation assistance and coordination.
- Employment, education, and vocational referrals.
- Life-skills education, including budgeting, money management, housekeeping, and maintaining a safe home.
- Referrals and service coordination for physical health, mental health, and substance use Treatment.

- Assistance obtaining identification and other essential documents.
- Food, clothing, household goods, and other basic-needs resources.
- Crisis intervention, problem-solving, and advocacy.
- Connections to local mainstream resources and community-based services; and
- Ongoing follow-up and support to promote long-term housing stability and community integration.

As a participant in **Franklin Court Chronically Homeless Program**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **once per 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 **Franklin Court Chronically Homeless 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, **Franklin Court Chronically Homeless 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 **ICCAP's PA0599 Permanent Supportive Housing for the Disabled 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.

ICCAP's PA0599 Permanent Supportive Housing for the Disabled 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 **ICCAP's PA0599 Permanent Supportive Housing for the Disabled 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.

ICCAP's PA0599 Permanent Supportive Housing for the Disabled Program provides the following supportive services to help participants obtain and retain permanent housing:

- Case management, budgeting, applying for Social Security, SNAP benefits, health care, etc. The Case Manager also provides transportation, as needed. Our goal is to provide enough support and referrals to help the individuals remain stably housed in this program and move to another permanent housing situation when they are ready.

As a participant in **ICCAP's PA0599 Permanent Supportive Housing for the Disabled Program**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least **1 time per month.**
- ☐ 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 **ICCAP's PA0599 Permanent Supportive Housing for the Disabled 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, **ICCAP's PA0599 Permanent Supportive Housing for the Disabled 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.

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Northwest Regional Housing Alliance (NWR)**. 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.

Northwest Regional Housing Alliance (NWR) 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 **Northwest Regional Housing Alliance (NWR)** 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.

Northwest Regional Housing Alliance (NWR) provides the following supportive services to help participants obtain and retain permanent housing:

- Leasing Assistance
- Case Management

As a participant in **Northwest Regional Housing Alliance (NWR)**, 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.

Northwest Regional Housing Alliance (NWR) is a treatment-focused program that requires all participants to engage in substance use treatment if identified on your housing stability plan. As a participant in **Northwest Regional Housing Alliance (NWR)**, 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.

Reasonable Accommodations If I have a disability that makes it difficult for me to meet **Northwest Regional Housing Alliance (NWR)**'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, **Northwest Regional Housing Alliance (NWR)** may consider further action under its written policies. Further action could include a written warning, a

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Turning Point**. 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.

Turning Point 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 **Turning Point** 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.

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

- Leasing Assistance
- Case Management

As a participant in **Turning Point**, 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.

Turning Point is a treatment-focused program that requires all participants to engage in substance use treatment if identified on your housing stability plan. As a participant in **Turning Point**, 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.

Reasonable Accommodations If I have a disability that makes it difficult for me to meet **Turning Point'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, **Turning Point** 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

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **My First Place 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.

My First Place 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 **My First Place 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.

My First Place TH provides the following supportive services to help participants obtain and retain permanent housing:

- Rental Assistance
- Case Management

As a participant in **My First Place TH**, 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.

My First Place TH is a treatment-focused program that requires all participants to engage in substance use treatment if identified on your housing stability plan. As a participant in **My First Place TH**, 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.

Reasonable Accommodations If I have a disability that makes it difficult for me to meet **My First Place 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, **My First Place 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

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **VetTH**. 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.

VetTH 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 **VetTH** 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.

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

- Rental Assistance
- Case Management

As a participant in **VetTH**, 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.

VetTH is a treatment-focused program that requires all participants to engage in substance use treatment if identified on your housing stability plan. As a participant in **VetTH**, 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.

Reasonable Accommodations If I have a disability that makes it difficult for me to meet **VetTH'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, **VetTH** 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

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **Team 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.

Team 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 **Team 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.

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

- Rental Assistance
- Case Management

As a participant in **Team TH**, 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.

Team TH is a treatment-focused program that requires all participants to engage in substance use treatment if identified on your housing stability plan. As a participant in **Team TH**, 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.

Reasonable Accommodations If I have a disability that makes it difficult for me to meet **Team 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, **Team 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

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to The Northwest 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.

The Northwest 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 The Northwest 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.

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

- **Housing Case Management**

As a participant in The Northwest Transitional Housing 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.
- ☐ 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 Northwest Transitional Housing 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, The Northwest 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.

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Chestnut Street 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.

Chestnut Street 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 Chestnut Street 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.

Chestnut Street 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 Chestnut Street 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 Chestnut Street 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, Chestnut Street 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:

_____ Western PA CoC DV TH

_____ Western 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

The Lighthouse Foundation

Supportive Services Agreement

Welcome to **The Lighthouse Foundation**. 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 Lighthouse Foundation 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 Lighthouse Foundation** 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).

The Lighthouse Foundation provides the following supportive services to help participants obtain and retain permanent housing:

Services include intensive case management, housing stabilization, budgeting and financial literacy, employment readiness, job search assistance, life skills education, transportation coordination, and assistance accessing mainstream benefits. Participants also receive support obtaining identification documents, addressing legal barriers, and securing permanent housing.

As a participant in **The Lighthouse Foundation**, I agree to:

- ☐ Meet or communicate with my assigned case manager at least weekly or 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.
- ☐ Report any major changes to program staff that may affect my housing, income, household, health, safety, or ability to participate in services.

☐ Notify program staff within 24 hours if I cannot attend a scheduled meeting and work with staff to reschedule.

Transitional Housing

☐ Participate in at least 30 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.

Requiring Mental Health or Substance Use Treatment

The Lighthouse Foundation is a treatment-focused program that requires all participants to engage in substance use treatment. As a participant in **The Lighthouse Foundation**, 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 **The Lighthouse Foundation'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, **The Lighthouse Foundation** 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

Transitional Housing Case Manager Signature

Date

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to **VOICE**! 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.

VOICE 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 **VOICE** 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).

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

- **Counseling**
- **Systems Advocacy**
- **Residential Housing Services**

As a participant in **VOICE**, 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 **VOICE** 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, **VOICE** 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 Washington County SWPA 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.

Washington County SWPA 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 **Washington County SWPA 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.

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

- Case Management
- Life Skills
- Transportation
- Connection to Mainstream Benefits
- Connection to Supportive Service Partners to address household needs

As a participant in **Washington County SWPA Transitional Housing**, 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.

Washington County SWPA Transitional Housing is a treatment-focused program that requires all participants to engage in substance use treatment. As a participant in **Washington County SWPA Transitional Housing** 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.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet Washington County SWPA 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, **Washington County SWPA 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 **Union Mission Permanent Supportive 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.

Union Mission Permanent Supportive 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 **Union Mission Permanent Supportive 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.

Union Mission Permanent Supportive Housing provides the following supportive services to help participants obtain and retain permanent housing:

- Case Management
- Life Skills
- Transportation
- Connection to Mainstream Benefits
- Connection to Supportive Service Partners to address household needs

As a participant in **Union Mission Permanent Supportive Housing**, 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.

Union Mission Permanent Supportive Housing is a treatment-focused program that requires all participants to engage in substance use treatment. As a participant in **Union Mission Permanent Supportive Housing** 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.

Reasonable Accommodations

If I have a disability that makes it difficult for me to meet **Union Mission Permanent Supportive 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, **Union Mission Permanent Supportive 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

WARREN FOREST EOC YOUNGSVILLE PSH

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Youngsville Forest EOC Warren 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.

Warren Forest EOC Youngsville 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 Warren Forest EOC Youngsville 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).

Warren Forest EOC Youngsville PSH provides the following supportive services to help participants obtain and retain permanent housing:

- Develop a personalized housing and service plan
- Assist with replacing identification and personal documents
- Transportation
- Connection to Mainstream Benefits
- Connection to employment and employer assistance
- Connection to continued education assistance
- Connection to community resources
- Housing search and navigation
- Landlord engagement
- Housing placement
- Housing stabilization
- Ongoing support to maintain permanent housing
- Case management services
- Healthcare and behavioral health referrals
- Substance abuse treatment referrals
- Life skills development
- Crisis intervention

As a participant in Warren Forest EOC Youngsville PSH, I agree to:

- Meet or communicate with my assigned case manager at least once 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.

If I have a disability that makes it difficult for me to meet Warren Forest EOC Youngsville 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.

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, Warren Forest EOC Youngsville 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.

WARREN FOREST EOC WARREN PSH

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

Welcome to Warren Forest EOC Warren 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.

Warren Forest EOC Warren 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 Warren Forest EOC Warren 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).

Warren Forest EOC Warren PSH provides the following supportive services to help participants obtain and retain permanent housing:

- Develop a personalized housing and service plan
- Assist with replacing identification and personal documents
- Transportation
- Connection to Mainstream Benefits
- Connection to employment and employer assistance
- Connection to continued education assistance
- Connection to community resources
- Housing search and navigation
- Landlord engagement
- Housing placement
- Housing stabilization
- Ongoing support to maintain permanent housing
- Case management services
- Healthcare and behavioral health referrals
- Substance abuse treatment referrals
- Life skills development
- Crisis intervention

As a participant in Warren Forest EOC Warren PSH, I agree to:

- Meet or communicate with my assigned case manager at least once 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.

If I have a disability that makes it difficult for me to meet Warren Forest EOC Warren 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.

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, Warren Forest EOC Warren 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.

Welcome to Westmoreland Community Action (WCA)'s **Permanent Supportive Housing (PSH) Program** (PA0600). 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.

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 enrolled in 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).

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

- ☐ Provide in-person Supportive Services weekly.
- ☐ Ensure each participant's confidentiality.
- ☐ Develop and maintain an individualized Service Plan for each participant, with reviews conducted at 30-, 60-, and 90-day intervals and revisions made as needed.
- ☐ Complete an annual assessment of participant needs.
- ☐ Provide support for maintaining independent housing, which includes, but is not limited to: a connection to other supportive services such as mental health, recovery, vocational, medical, credit counseling services, clothing closets, etc.
- ☐ Arrange transportation needs (grocery shopping, food bank, etc.) *The Program Specialist reserves the right to suspend/terminate transportation services for disruptive behaviors.*
- ☐ Facilitate connections to other employment services such as Recovery Employment, PA Office of Vocational Rehabilitation (OVR) and other employment support services.
- ☐ Assist in employment search or connection to other employment services mentioned above.
- ☐ Provide assistance with Life Skills and Self-Sufficiency Support Services to participants which includes, but is not limited to: completing employment applications, interview preparation, budget development, credit repair assistance, meal planning and conflict resolution.
- ☐ Other services within the scope of the program to ensure successful discharge to independent housing.

As a participant in PSH, I agree to:

- ☐ Comply with WCA's Housing Lease Agreement as part of the Supportive Services Agreement
- ☐ 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.
- ☐ Participate in 30-day, 60-day or 90-day Service Plan reviews.

If I have a disability that makes it difficult for me to meet the 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.

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, Westmoreland Community Action 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.

Welcome to Westmoreland Community Action (WCA)'s **Transitional Housing (TH) Youth Homelessness Demonstration Program** (PA1059). 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.

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 enrolled in YHDP 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).

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

- ☐ Provide in-person Supportive Services weekly.
- ☐ Ensure each participant's confidentiality.
- ☐ Develop and maintain an individualized Service Plan for each participant, with reviews conducted at 30-, 60-, and 90-day intervals and revisions made as needed.
- ☐ Complete an annual assessment of participant needs.
- ☐ Provide support for maintaining independent housing, which includes, but is not limited to: a connection to other supportive services such as mental health, recovery, vocational, medical, credit counseling services, clothing closets, etc.
- ☐ Arrange transportation needs (grocery shopping, food bank, etc.) *The Program Specialist reserves the right to suspend/terminate transportation services for disruptive behaviors.*
- ☐ Facilitate connections to other employment services such as Recovery Employment, PA Office of Vocational Rehabilitation (OVR) and other employment support services.
- ☐ Assist in employment search or connection to other employment services mentioned above.
- ☐ Provide assistance with Life Skills and Self-Sufficiency Support Services to participants which includes, but is not limited to: completing employment applications, interview preparation, budget development, credit repair assistance, meal planning and conflict resolution.
- ☐ Other services within the scope of the program to ensure successful discharge to independent housing.

As a participant in YHDP TH, I agree to:

- ☐ Comply with WCA Transitional Housing Lease Agreement as part of the Supportive Services Agreement
- ☐ 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.
- ☐ Participate in 30-day, 60-day or 90-day Service Plan reviews.

If I have a disability that makes it difficult for me to meet the 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.

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, Westmoreland Community Action 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.

Adult Regional TH - Recovery Focused

Welcome to Westmoreland Community Action (WCA)'s **Regional Recovery-Focused Transitional Housing (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.

Regional Recovery-Focused 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 enrolled in Regional Recovery-Focused 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).

Regional Recovery-Focused TH provides the following supportive services to help participants obtain and retain permanent housing:

- ☐ Provide in-person Supportive Services weekly.
- ☐ Ensure each participant's confidentiality.
- ☐ Develop and maintain an individualized Service Plan for each participant, with reviews conducted at 30-, 60-, and 90-day intervals and revisions made as needed.
- ☐ Complete an annual assessment of participant needs.
- ☐ Provide support for maintaining independent housing, which includes, but is not limited to: a connection to other supportive services such as mental health, recovery, vocational, medical, credit counseling services, clothing closets, etc.
- ☐ Arrange transportation needs (grocery shopping, food bank, etc.) *The Program Specialist reserves the right to suspend/terminate transportation services for disruptive behaviors.*
- ☐ Facilitate connections to other employment services such as Recovery Employment, PA Office of Vocational Rehabilitation (OVR) and other employment support services.
- ☐ Assist in employment search or connection to other employment services mentioned above.
- ☐ Provide assistance with Life Skills and Self-Sufficiency Support Services to participants which includes, but is not limited to: completing employment applications, interview preparation, budget development, credit repair assistance, meal planning and conflict resolution.
- ☐ Other services within the scope of the program to ensure successful discharge to independent housing.

As a participant in Regional Recovery-Focused TH, I agree to:

- ☐ Comply with WCA Transitional Housing Lease Agreement as part of the Supportive Services Agreement
- ☐ 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.
- ☐ Participate in 30-day, 60-day or 90-day Service Plan reviews.

SUBSTANCE USE TREATMENT

Regional Recovery-Focused TH is a treatment-focused program that requires all participants to engage in substance use treatment.

As a participant in Regional Recovery-Focused TH 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 the Regional Recovery-Focused 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.

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, Westmoreland Community Action 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.

My signature indicates that I have reviewed and agree to abide by this Supportive Services Agreement. All questions pertaining to this agreement were answered by the Program Specialist. I understand that participation in Supportive Services is NOT VOLUNTARY, and I can be asked to leave the WCA Transitional Housing program for non-compliance at any time. I also understand that the Supportive Services Agreement is also part of the Lease Agreement and any violation of this agreement will be just cause for an Eviction Notice to be served. By accepting this Supportive Services Agreement, I agree to the terms and conditions of this agreement, the Lease Agreement, and agree to abide by them.

Participant

Date

Program Specialist

Date

Adult Services Manager/Director

Date

FY 2026

PA-601 Western Pennsylvania

Continuum of Care

1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety

Documents include the following:

- **Letter of Agreement between Westmoreland Community Action and the following Police Department for the purpose of establishing a collaborative working relationship to support individuals experiencing mental health crises within Westmoreland County.**
 - **The City of Latrobe Police Department**
 - **Forbes State Forest Police Department**
 - **Murrysville Police Department.**
 - **City of New Kensington Police Department.**

- **Mount Pleasant Borough Police Department**
- **Ligonier Valley Police Department**
- **North Huntingdon Township Police Department**
- **Trafford Police Department**
- **Upper Burrell Township Police Department**
- **Monessen Police Department**
- **Vandergrift Police Department**
- **West Leechburg Police Department**
- **Penn Township Police Department**
- **Washington Township Police Department**
- **The Manor Borough Police Department**
- **City of Greensburg Police Department**
- **Delmont Borough Police Department**
- **Memorandum of Understanding between Westmoreland County Drug Treatment Court and Westmoreland Community Action for the purpose of improving housing stability and recovery outcomes for individuals with substance use disorders involved in the court system.**



LETTER OF AGREEMENT

This Letter of Agreement is entered into by and between **Westmoreland Community Action – Mobile Crisis Program** and The City of LATROBE (Police Department), for the purpose of establishing a collaborative working relationship to support individuals experiencing mental health crises within Westmoreland County.

The Mobile Crisis Program provides on-site crisis intervention, assessment, de-escalation, and linkage to appropriate behavioral health services. This partnership is intended to enhance law enforcement response by offering clinical support during mental health-related incidents, with the shared goal of promoting safety, reducing unnecessary hospitalizations or incarcerations, and connecting individuals to appropriate care.

This Agreement reflects the mutual understanding that both parties will collaborate, when appropriate, in responding to individuals in crisis. Such collaboration may include on-scene response, consultation, coordination of care, and referral to ongoing services. This Agreement does not create any contractual, financial, or legal obligations, nor does it imply affiliation, endorsement, or shared liability between the parties.

Both parties agree to respect and protect the confidentiality of all individuals served and to comply with all applicable federal and state regulations, including the Health Insurance Portability and Accountability Act (HIPAA). Information will only be shared as permitted by law and, when required, with appropriate authorization.

It is expected that both parties will maintain open communication regarding any significant changes in services, procedures, or points of contact that may impact this collaboration. Either party may request to review or revise this Agreement as needed. This Agreement shall remain in effect unless terminated by either party with written notice.

We value the opportunity to work collaboratively in support of the community and appreciate your partnership in responding to mental health crises.

Sincerely,

Westmoreland Community Action
Mobile Crisis Program

By: _____
Name/Title: Kris Detar, Mental Health
Date: 5/18/2020 Services Director

Police Department

By: [Signature]
Name/Title: CHIEF of POLICE
Department: LATROBE PD
Date: 5/18-2020



LETTER OF AGREEMENT

This Letter of Agreement is entered into by and between **Westmoreland Community Action – Mobile Crisis Program** and Forbes State Forest (Police Department), for the purpose of establishing a collaborative working relationship to support individuals experiencing mental health crises within Westmoreland County.

The Mobile Crisis Program provides on-site crisis intervention, assessment, de-escalation, and linkage to appropriate behavioral health services. This partnership is intended to enhance law enforcement response by offering clinical support during mental health-related incidents, with the shared goal of promoting safety, reducing unnecessary hospitalizations or incarcerations, and connecting individuals to appropriate care.

This Agreement reflects the mutual understanding that both parties will collaborate, when appropriate, in responding to individuals in crisis. Such collaboration may include on-scene response, consultation, coordination of care, and referral to ongoing services. This Agreement does not create any contractual, financial, or legal obligations, nor does it imply affiliation, endorsement, or shared liability between the parties.

Both parties agree to respect and protect the confidentiality of all individuals served and to comply with all applicable federal and state regulations, including the Health Insurance Portability and Accountability Act (HIPAA). Information will only be shared as permitted by law and, when required, with appropriate authorization.

It is expected that both parties will maintain open communication regarding any significant changes in services, procedures, or points of contact that may impact this collaboration. Either party may request to review or revise this Agreement as needed. This Agreement shall remain in effect unless terminated by either party with written notice.

We value the opportunity to work collaboratively in support of the community and appreciate your partnership in responding to mental health crises.

Sincerely,

Westmoreland Community Action
Mobile Crisis Program

By: _____
Name/Title: Kris Detar, Mental Health
Date: 5/18/2026 Programs Director

Police Department

By: [Signature]
Name/Title: Johal Kaminsky Chief
Department: DCNK Forbes
Date: 5/18/26



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and Morrisville PD
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.

Chris R. Spill
Authorized Representative Signature

11/19/19
Date

Tracey Deunelle
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and City of New Kensington Police Dept.
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.

Robert A. Deringer, Chief of Police
Authorized Representative Signature

19 November 2019
Date

Stacey A. Bennett
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and MT. Pleasant Borough PD
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.

Chief M. A. H.
Authorized Representative Signature

11-22-19
Date

Stacey A. Sennese
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and Ligonier Valley
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.

[Signature]
Authorized Representative Signature

[Signature]
WCA Representative Signature

11-22-19
Date

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and NORTH HUNTINGDON Twp PD
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.

[Signature]
Authorized Representative Signature *Chief of Police*

11-25-19
Date

[Signature]
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and

TRAFALGAR POLICE DEPT.
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

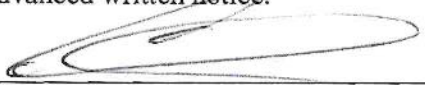
This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.



Authorized Representative Signature

11/21/19

Date



WCA Representative Signature

November 8, 2019

Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and

UPPER Merrell Twp
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.

Chip [Signature]
Authorized Representative Signature

NOV 21, 2019
Date

Stacey Bennett
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and Monessen Police Dept
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

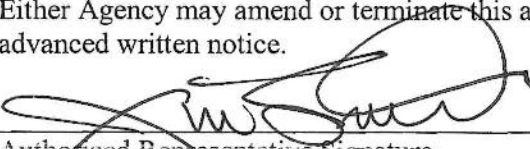
This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

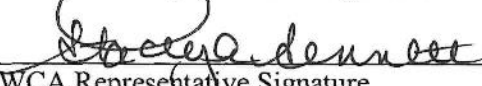
Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12-month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30-day advanced written notice.


Authorized Representative Signature


WCA Representative Signature

11/20/19
Date

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and VANDERGRIFT
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12- month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30- day advanced written notice.

Joseph M. Caporali
Authorized Representative Signature

11-20-19
Date

Stacey A. Bennett
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and West Leechburg Police Dept.
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12- month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30- day advanced written notice.

P. King, Police Chief
Authorized Representative Signature

January 11, 2020
Date

[Signature]
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and

PENN TOWNSHIP POLICE
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12- month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30- day advanced written notice.

[Signature]
Authorized Representative Signature

11.26.2019
Date

[Signature]
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and Washington Twp. PD
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12- month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30- day advanced written notice.

Chris [Signature]
Authorized Representative Signature

December 9, 2019
Date

Stacey Bennett
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and THE MANOR BEZQUE POLICE
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

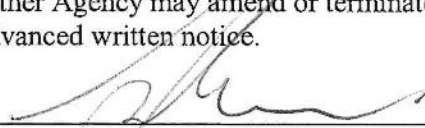
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Westmoreland Community Action Mental Health Programs provide the following services:

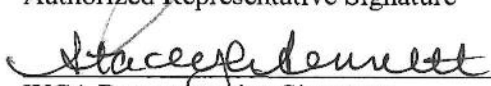
- Crisis Hotline
- Mobile Crisis

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Authorized Representative Signature



WCA Representative Signature

12/2/2019

Date

November 8, 2019

Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and CITY OF GREENSBURG
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

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- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12- month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30- day advanced written notice.

[Signature]
Authorized Representative Signature

12-30-19
Date

[Signature]
WCA Representative Signature

November 8, 2019
Date



LETTER OF AGREEMENT

Westmoreland Community Action's Crisis Programs and Delmont Borough Police Department
(Police Department Name)

acknowledge their shared interest in collaborating and cooperatively working together to provide services and support to Westmoreland County community members suffering from mental illness.

This Agreement recognizes that a collaborative relationship exists between the Organizations for the benefit of mental health consumers in Westmoreland County. This Agreement signifies the Organizations' willingness to work together when mental health crises occur in the community. This Agreement is neither a fiscal nor an obligation of funds document. It does not imply any affiliation, contract, endorsement, or shared liability between Organizations.

Westmoreland Community Action Mental Health Programs provide the following services:

- Crisis Hotline
- Mobile Crisis

Both Agencies will respect the confidentiality of information for the consumer(s) and use appropriate safeguards to prevent use or disclosure of protected health information according to HIPAA regulations.

This agreement is effective for a 12-month period beginning on the date indicated below and shall automatically renew for successive 12- month terms unless amended or terminated by either Agency. Either Agency may amend or terminate this agreement by providing the other Agency with a 30- day advanced written notice.

Chief [Signature]
Authorized Representative Signature

11/27/2019
Date

[Signature]
WCA Representative Signature

November 8, 2019
Date

MEMORANDUM OF UNDERSTANDING
Between
Westmoreland County Drug Treatment Court
And
Westmoreland Community Action

I. Parties

This Memorandum of Understanding (MOU) is made on July 31, 2026 between Westmoreland County Drug Treatment Court (hereafter referred to as WCDTC) and Westmoreland Community Action (hereafter referred to as WCA) for the purposes of improving housing stability and recovery outcomes for individuals with substance use disorders involved in the court system. This MOU pertains to the period of grant operation, spanning from October 1, 2026, through September 30, 2027.

II. Obligations of the Parties

- a. The Parties agree to maintain communication and share information to identify individuals eligible or interested in housing support services.

III. Responsibilities of Parties

a. WCDTC Shall:

- i. Identify and document participants experiencing homelessness or housing instability in alignment with their own standard assessment practices and procedures.
- ii. Refer individuals potentially eligible for support serves to WCA and provide relevant documentation to support housing eligibility, including verification of homelessness where applicable.
- iv. Coordinate with WCA to expedite housing placement or the delivery of support services
- v. Allow WCA staff access (as appropriate) to court or program settings to facilitate engagement and assessments
- vi. Participate in ongoing case coordination meetings

b. WCA Shall:

- i. Establish a direct referral pathway from the Drug Treatment Court to the Continuum of Care (CoC) Coordinated Entry (CE) system and/or WCA's other housing, mental health, recovery or other support services for all eligible individuals.
- ii. Provide ongoing housing stabilization services and supportive case management to clients involved with the WCDTC including reminders and transportation to court dates and probation appointments.
- iii Coordinate closely with WCDTC to align referral practices and share aggregate referral and outcome data to demonstrate partnership effectiveness.

IV. Duration of MOU

- a. WCA and WCDTC will renew automatically. Either party may terminate the agreement upon written request.

SIGNATURES:

Westmoreland Community Action

Signature

Title

Date

Westmoreland County Drug Treatment Court

Signature

Title

Date

Witness

Signature

Title

Date

[Handwritten signatures and dates in blue ink]

<u>[Signature]</u>	<u>CEO</u>	<u>7-27-26</u>
<u>[Signature]</u>	<u>President Judge</u>	<u>7/14/2026</u>
<u>[Signature]</u>	<u>CAO</u>	<u>7/27/26</u>

FY 2026

PA-601 – Western Pennsylvania

Continuum of Care

1D-1. Local Competition Scoring Tool

Documents include the following:

- **Summary of renewal project scoring criteria meeting rating factor thresholds**
- **Western PA CoC: 2026 Renewal Project Scoring Criteria (non-YHDP projects)**
- **Western PA CoC: 2026 Renewal Project Scoring Criteria (YHDP projects)**
- **Summary of renewal project scoring criteria meeting rating factor thresholds**
- **Western 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:

1. **See renewal project scoring criteria documents for Non-YHDP and YHDP projects 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 accounted for 100% of the criteria and related points included in the renewal project scoring tools for non-YHDP and YHDP PSH, RRH, TH, TH/RRH, and SSO projects.
3. System performance measures were used and account for at least 25% of the total points available. **The following renewal project criteria are related to system performance. System performance criteria for non-YHDP and YHDP PSH and RRH/TH-RRH made up 20 out of 74.5 points (26.8%), non-YHDP and YHDP TH made up 20 out of 76.5 points (26.1%) and non-YHDP and YHDP SSO made up 18 out of 71.5 points (25.2%) 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	0	10	10
2	Returns to Homelessness	2	2	2	2	0
6	Length of time between Project Start Date and Housing Move-in Date	0	0	0	0	0
7	Increase in total income	7	7	7	7	7
8	Employment Income Growth	1	1	1	1	1

4. For housing projects (non-YHDP and YHDP 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
8	Employment Income Growth	1	1	1	1	1
24	Service Participation	2	2	2	2	0

Western PA CoC: 2026 Renewal Project Scoring Criteria

Approved by Funding Committee: 2/10/26

- Updated 6/17/2026: Minor updates based on NOFO requirements; removed CE Participation as scored criteria in 2026

The time period used for all data will be January 1, 2025 - December 31, 2025

#	Criteria	Data Source	Point Structure
Performance and Data Quality: RRH/ TH-RRH/PSH/ SSO = 43.5 points; TH = 45.5 points			
1a	<u>TH/SSO- Housing Stability:</u> TH & SSO Only <u>TH Measurement:</u> % of participants/leavers who exited to permanent housing destination. <u>SSO Measurement:</u> % of participants/leavers who were placed into Emergency Shelter, Transitional Housing or Permanent Housing <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 <u>Note:</u> For DV-dedicated projects, housing stability criteria will also include exits to temporary housing destinations as a positive exit. CoC average outcomes in 2025: 100%	APR pulled from HMIS; APR from DV providers	TH 98% = 10 points 94-97%= 8 points 88-93% = 6 points 83-87% = 4 points SSO 98% = 10 points 94-97%= 8 points 88-93% -6 points 83-87% = 4 points
1b	<u>RRH/TH-RRH/PSH – Housing Stability:</u> RRH, TH-RRH & PSH Only <u>RRH Measurement:</u> % of participants/leavers who exited to permanent housing destination.	APR pulled from HMIS; APR from DV providers	RRH % exits to permanent housing; TH/RRH % exits to permanent housing or transitional housing PSH % remained in permanent housing or exited to permanent housing:

	TH-RRH Measurement: % of participants/leavers who exited to permanent housing destination or transitional housing. PSH Measurement: % of participants/stayers who remained in PSH project or participants/leavers who exited to other permanent housing. Note: 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 Note: For DV-dedicated projects, housing stability criteria will also include exits to temporary housing destinations as a positive exit. CoC average outcomes in 2025: 96%		• 98% = 10 points • 94-97%= 8 points • 88-93% = 6 points • 83-87% = 4 points
2	% Returns to Homelessness: Percentage of adults return to homelessness within 6 months of program exit to a permanent housing destination. • Note: N/A for Victim Service Providers, as there is no way to measure if clients reentered the system, only their specific program. • N/A for SSO CoC average outcomes in 2025: 0.8%	HMIS	• 0 - 5% returns to homelessness within 6 months of program exit = 2 points • 6 - 10% = 1 point • >10% = 0 points
3	Projects Operated by a Victim Service Provider - Quarterly Monitoring Projects operated by a Victim Service Provider 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:	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

	• 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		
4	<u>Length of Stay/Average:</u> TH and SSO Only - Average length of stay for leavers	APR pulled from HMIS; APR from DV providers	• Less than 9 months (274 days or less) = 1 point • 9 - 12 months (275 to 365 days) = 0.5 points
5	<u>Length of Stay/Less than 12 months:</u> TH and SSO Only - The percentage of participants whose length of stay is 12 months or less	APR pulled from HMIS; APR from DV providers	• 90%+ = 1 point • 80-89% = 0.5 points
6 Not scored in 2026	<u>Length of time between Project Start Date and Housing Move-in Date (RRH, TH-RRH, and PSH only)- Average</u> 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) <i>This criterion will be evaluated in 2026 but will not be scored.</i> N/A for TH and SSO	APR pulled from HMIS; APR from DV providers	Target: 30 days or less (average) Not scored in 2026
7	<u>Increase in Total Income:</u> % 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. CoC average outcomes in 2025: 53%	APR pulled from HMIS; APR from DV providers	• 55% or more had an increase in total income = 7 points • 45-54% increase income = 6 points • 35-44% increase income = 4 points • 25-34% increase income = 3 points
8	<u>Employment Income Growth:</u> 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) CoC average outcomes in 2025: 24%		• 25%+ = 1 point • 15-24% = 0.5 points

9	Participants with any Income - % of adult participants with 1+ source of income at exit/annual assessment (leavers and stayers) CoC average outcomes in 2025: 68%	APR pulled from HMIS; APR from DV providers	● 60%+ = 3 points ● 50-59% = 2 points ● 40-49% = 1 point
10	Participants Connected to Mainstream Benefits % of adult participants with 1+ source of Non-Cash benefits (SNAP, WIC, TANF, others, etc.) CoC average outcomes in 2025: 82%	APR pulled from HMIS; APR from DV providers	● 90%+ = 5 points ● 80-89% = 4 points ● 70-79% = 3 points ● 60-69% = 2 points
11	Participants Connected to Health Insurance: Percentage of all participants with 1+ source of health insurance CoC average outcomes in 2025: 93%	APR pulled from HMIS; APR from DV providers	● 95%+ = 4 points ● 90-94% = 3 points ● 85-89% = 2 points ● 80-84% = 1 point
12	High Quality Data Entry: % 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 ● 11.a. – 0% error rate – 0.5 points ● 11.b. – 0% error rate – 0.5 points ● 11.c. – 0% error rate – 0.5 points ● 11.d. – 0% error rate – 1.5 points ● 11.e. – 0% error rate – 1.5 points ● 11.f. – 0% error rate – 1.5 points ● 11.g. – 0% error rate – 1.5 points

13	<u>Timeliness of Data Entry</u> <u>a. % of project entry records entered into HMIS (or DV comparable database) within 10 days</u> <u>b. % of project exit records entered into HMIS (or DV comparable database) within 10 days</u> 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. This criterion evaluates whether data was entered within 10 days. 2025 CoC average Outcomes Entries: 77% 2025 CoC average Outcomes Exits: 77%	APR pulled from HMIS; APR from DV providers	4 points total a. Entry records • 100% of project entry records input within 0-10 days – 2 points • 90% of project entry records within 0-10 days – 1.5 points • 80% of project entry records input within 0-10 days – 1 point • 70% of project entry records within 0-10 days – 0.5 points b. Exit records • 100% of project exit records input within 0-10 days - 2 points • 90% of project exit records within 0-10 days – 1.5 points • 80% of project exit records input within 0-10 days – 1 point • 70% of project exit records within 0-10 days – 0.5 points
Grant Management/Monitoring = 15 points PSH/RRH/TH-RRH/TH; 12 points SSO			
14	<u>Participant Eligibility:</u> % of heads of household (entering the project during the data lookback period) whose prior living situation was reported as literally homeless situations or fleeing DV Prior residence of adult participants 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-threatening conditions that relate to violence against the individual or family member)	APR validation file (HMIS-participating projects) and RSF data	• 100% of adult heads of household served were literally homeless/fleeing DV = 2 points • 94-99% of adult heads of household served were literally homeless/fleeing DV = 1 points

	If agencies enrolled heads of household who entered via a project transfer, this will need to be reported to DMA via the Renewal Summary Form process.		
15	Unit Utilization: Average utilization/occupancy rate of project Average utilization rate of project (using project utilization each quarter, as reported on APR) • N/A for SSO (SSO projects are not scored on this criterion; however, SSO projects will be evaluated on utilization compared to renewal application and if there are concerns with utilization those will be raised with the Funding Committee). For projects with under 10 units, will use a 3-year average if the project is under 80% utilization.	# units per 2025 renewal app (or 2024, if 2025 renewal app not submitted) compared to average unit utilization; APR pulled from HMIS; APR from DV providers	• 90+ utilization rate = 3 points • 85-89% = 2 points • 80-84% = 1 point
16	Funds Expended: % of grant funds expended. Ensure project is fully utilizing CoC funding. Goal = full spend down If less than 90% expended, grantee will be asked to submit a supplemental form related to grant spending over last 3 years and projected spending.	e-LOCCS and/or Sage data	• 100% of funds expended = 8 points • 95% - 99% expended = 6 points • 90% - 94% expended = 2 points • <90% expended = 0 points
17	Timely APR submission APR submitted within 90 days of end of grant (HUD requirement)	Last submitted APR (Sag)	• Timely submission = 2 points • Submitted beyond 90 days = 0 points
HUD/CoC Priorities = 4 points			
18	Lived Experience on Board • Grantee has a minimum of one homeless individual or formerly homeless individual on the board of directors or other equivalent policymaking entity of the recipient or subrecipient OR grantee has received HUD approval for a plan to otherwise consult with homeless or formerly homeless individuals when considering and making policies and decisions. This is a HUD requirement per CoC Interim Rule Section 578.75(g).	Renewal Summary Form	Maximum 2 points • Organization affirms that they have a homeless individual or formerly homeless individual on the board of directors = 2 points OR • Organization shows documentation that HUD has approved an alternate plan for involving

			individuals with lived experience in decision-making = 2 points • Org does not meet above requirement = 0 points
24 (added)	<u>Service Participation</u> • CoC grantee requires participation in services in alignment with CoC and HUD requirements, except where prohibited by federal law.	CoC monitoring records	2 points for submission of service participation requirement.
CoC Participation = 12 points PSH/RRH/TH-RRH/TH/SSO			
19	<u>CoC meetings</u> • CoC Meeting Attendance. Full participation in CoC is expected in order to further the goals of the CoC. ■ For projects with one or more subrecipients, expectation is that recipient AND 50% or more of all subrecipients must attend CoC meeting to receive points. ■ Grantees will be asked to provide a list of all subrecipients as part of the Renewal Summary Form. 2025 Full CoC Meeting Dates: 3/19/25 (in person), 9/3/25 (in person), 12/17/25 (virtual)	RSF & CoC meeting sign-in sheets and/or Zoom records	2 total points • Attendance at 2 out of 3 CoC meetings (or more) = 2 points • Attendance at 1 out of 3 CoC meetings = 1 point • Attendance at 0 CoC meetings = 0 points
20a	<u>Regional Homeless Advisory Board (RHAB) meetings</u> • Participation in RHAB meeting (Southwest RHAB) or Northwest Housing Collaborative Meeting (Northwest RHAB). 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 50% or more RHAB meetings in all RHABs they serve. ■ Grantees will be asked to provide a list of all subrecipients as part of the Renewal Summary Form.	RSF & RHAB attendance sheets and/or Zoom records	• Attended at least 50% of all RHAB or Northwest Housing Collaborative meetings in 2025 = 2 points • Projects serving more than 1 RHAB will be able to earn a maximum of 4 points on this criteria, as they are excluded from LHOT criteria.
20b	<u>County LHOT or housing coalition meetings</u> • Participation in county LHOT or Housing Coalition Meetings. Full participation in county LHOT or housing coalition meetings is expected in order to further the goals of the CoC.	Letter signed by Chair of county entity	Attendance at 75% or more of all county LHOT/housing coalition meetings = 2 points

	NOTE: Projects serving more than 1 RHAB are EXCLUDED from LHOT criteria. Projects serving more than 1 RHAB will be able to earn a maximum of 4 points on the RHAB criteria.		
21	Participation in CoC Training Events Full participation in webinar and training opportunities is expected of all CoC funded organizations - For projects with one or more subrecipients, expectation is that, at a minimum, 50 % or more of all subrecipients must attend CoC training to receive points. - Recipient is strongly encouraged to also attend trainings. - Grantees will be asked to provide a list of all subrecipients as part of the Renewal Summary Form. - Grantees are strongly encouraged to attend trainings live. However, for virtual trainings watching recorded trainings does count toward attendance. Attendee MUST submit an attendance survey to document that they watched the training.	RSF & Attendance sheets and/or Zoom records	Attendance at CoC training events is expected of organizations receiving CoC funding. Maximum Points = 6 points 2025 required trainings: - Fair Housing, Equal Access and Landlord/Tenant Law Training – 5/12/25 webinar – 1 point - Mainstream Benefits Training (PA DHS Mainstream Benefits and Programs) – 5/19/25 webinar – 1 point - West Written Standards Training Part 1 – 3/13/25 webinar – 1 point - West Written Standards Training Part 2 – 3/26/25 webinar – 1 point - Best practices in Housing Retention Training (for RRH and PSH) – Training offered 6/2/25, 6/3/25, 6/4/25, 6/5/25. – 2 points
22	Coordinated Entry Participation - Participation in Case Conferencing 100% of Project Enrollments Referred Through CE (For Victim Service Providers this will be self-report) - N/A for SSO projects - Record Referral Outcomes for All HMIS Referrals - N/A for SSO projects - N/A for VSPs	PA HMIS data and data from CE Managers	2-points total 22a. CE case conferencing – 75%+ attendance at case conferencing meetings = 0.5 points 22b. 100% of Project Enrollments Referred through CE = 1-point

Not scored in 2026

	In future years, the CoC also plans to evaluate grantees not rejecting/screening participants out for non-eligible reasons (once a policy is established related to this).		22c. 100% Referral outcomes logged in HMIS = 0.5 points Not scored in 2026
23	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– 74.5 points
- TH – 76.5 points
- SSO – 71.5 points

*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

Criteria #	Criteria	Calculation
1a	TH/SSO – HOUSING STABILITY TH Measurement: % of participants/leavers who exited to permanent housing destination among those who exited project. SSO Measurement: % of participants/leavers who were placed into Emergency Shelter, Transitional Housing or Permanent Housing	TH 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) <u>DV-dedicated projects only: Total persons exiting to temporary housing destinations will be included in the numerator.</u> SSO Q23c: Exit Destination <u>Numerator:</u> (Q23c-Total persons exiting to permanent housing destinations) + (Q23c-Total persons exiting to temporary housing destinations) + 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>DV-dedicated projects only: Total persons exiting to temporary housing destinations will be included in the numerator.</u> <u>Note for TH and SSO:</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	RRH/TH-RRH/PSH- HOUSING STABILITY <u>RRH Measurement:</u> % of participants/leavers who exited to	RRH: APR Q23c: Exit Destination <u>Numerator:</u> (Q23c-Total persons exiting to positive housing destinations)

	permanent housing destination among those who exited project. <u>PSH Measurement:</u> % of participants/stayers who remained in PSH project or participants/leavers who exited to other permanent housing.	<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>DV-dedicated projects only: Total persons exiting to temporary housing destinations will be included in the numerator.</u> TH-RRH: APR Q23c: Exit Destination <u>Numerator:</u> (Q23c-Total persons exiting to positive housing destinations) + (Q23c-Transitional housing) <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>DV-dedicated projects only: Total persons exiting to temporary housing destinations will be included in the numerator (which includes transitional housing).</u> PSH: APR Q1 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) <u>DV-dedicated projects only: Total persons exiting to temporary housing destinations will be included in the numerator.</u> <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
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2	RETURNS TO HOMELESSNES % of adults return to homelessness within 6 months of program exit to a permanent housing destination <i>N/A for DV providers</i>	SPM 2ab Data File – Returns to Homelessness <u>Numerator:</u> # of Adults who returned to an ES, TH or SH projects within 6 months of Exit to Permanent Housing <u>Denominator:</u> # Clients who exited from program to a permanent housing destination between 7/1/24-12/31/25
3	DV-DEDICATED PROJECTS - QUARTERLY MONITORING	CoC records of submission of APR data on a quarterly basis, by stated deadline
4	LENGTH OF STAY/AVERAGE (TH AND SSO ONLY) Average length of stay for leavers	APR Q22b: Average and Median Length of Participation in Days Average Length-Leavers
5	LENGTH OF STAY/LONGER THAN 12 MONTHS (TH AND SSO ONLY) The percent of participants whose length of stay is 12 months or less	APR Q22a1: Length of Participation – CoC Projects <u>Numerator:</u> (Total-30 days or less) + (Total-31 to 60 days) + (Total-61 to 90 days) + (Total-91 to 180 days) + (Total-181 to 365 days) <u>Denominator:</u> (Total-Total)
6 Not scored in 2026	LENGTH OF TIME BETWEEN PROJECT START DATE AND RESIDENTIAL MOVE IN	Q22c: Length of Time between Project Start Date and Housing Move-in Date Average length of time to housing: Total Not scored in 2026
7	INCREASE IN 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)
8	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)
9	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)
10	CONNECTING PARTICIPANTS TO MAINSTREAM BENEFITS Percent 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)
11	PARTICIPANTS CONNECTED TO HEALTH INSURANCE	APR Q21: Health Insurance; APR Q5: Report Validation Table

	Percentage of all participants with 1+ source of health insurance	<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) <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)
12	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/Ethnicity 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/dating violence/sexual assault/human trafficking/stalking 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)
13	TIMELINESS OF HMIS DATA ENTRY a. % of project entry records entered into HMIS within 10 days	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. % of project exit records entered into HMIS within 10 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 12.a. Projects with no exits won't be scored on 12.b.
14	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	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 adult heads of household whose prior living situation was literally homeless OR participant reports currently fleeing DV. Numerator: # of heads of household enrolled between 1/1/25-12/31/25 who were literally homeless and/or fleeing DV at project entry Denominator: Total # of heads of household enrolled between 1/1/25-12/31/25 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

15	UNIT UTILIZATION RATES Average utilization/occupancy rate of project (using project utilization each quarter, as reported on APR) (N/A for SSO)	Information provided in the Renewal Project Summary Form survey will be considered in calculating utilization. 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 80% utilization.
16	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.
17	TIMELY APR SUBMISSION APR submitted within 90 days of end of grant	Review of Sage data
18	LIVED EXPERIENCE ON BOARD	Review of RSF information submitted by agency
24	Service Participation	Review of RSF documentation submitted by agency
19	COC MEETINGS CoC Meeting Attendance	Review of RSF documentation submitted by agency, meeting sign in records, and online survey attendance submissions
20a	REGIONAL HOMELESS ADVISORY BOARD (RHAB) MEETINGS Participation in RHAB meetings	Review of RSF documentation submitted by agency, sign in records submission from RHAB meetings, and documentation from RHAB chairs
20b	COUNTY LHOT OR HOUSING COALITION MEETINGS Participation in county LHOT or Housing Coalition Meetings	Review of RSF documentation submitted by agency, sign in records from LHOT meetings, and documentation from LHOT chairs
21	PARTICIPATION IN COC TRAINING EVENTS	Review of RSF documentation submitted by agency, webinar/training sign in records, and online survey attendance submissions
22 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
23	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

Western PA CoC: 2026 Renewal Project Scoring Criteria

YHDP Projects

Approved by Funding Committee: 2/10/2026

- Updated 6/17/2026: Minor updates based on NOFO requirements; removed CE Participation as scored criteria in 2026

The time period used for all data will be January 1, 2025 - December 31, 2025

#	Criteria	Data Source	Point Structure
Performance and Data Quality: RRH/TH-RRH/PSH/SSO = 43.5 points; TH = 45.5 points			
1a	<u>TH/SSO/TH-RRH- Housing Stability:</u> <u>TH Measurement:</u> % of participants/leavers who exited to permanent housing destination. <u>SSO Measurement:</u> % of participants/leavers who were placed into Emergency Shelter, Temporary Housing or Permanent Housing <u>TH-RRH Measurement:</u> % of participants/leavers who exited to Permanent housing destination or Transitional housing. <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 YHDP average outcomes in 2025: 90%	APR pulled from HMIS; APR from DV providers	TH/SSO/TH-RRH 93% = 10 points 87-92% = 8 points 81-86% = 6 points 75-80% = 4 points
1b	<u>PSH – Housing Stability</u> <u>PSH Measurement:</u> % of participants/stayers who remained in PSH project or participants/leavers who exited to other permanent housing.	APR pulled from HMIS; APR from DV providers	98% = 10 points 94-97% = 8 points 88-93% = 6 points 83-87% = 4 points

	Note: 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 YHDP average outcomes in 2025: 100%		
2	% Returns to Homelessness: Percentage of adults return to homelessness within 6 months of program exit to a 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 YHDP average outcomes in 2025: 0%	HMIS	• 0 - 5% returns to homelessness within 6 months of program exit = 2 points • 6 - 10% = 1 point • >10% = 0 points
3	Projects Operated by Victim Service Providers - Quarterly Monitoring Projects operated by Victim Service Providers 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	N/A for YHDP projects

4	<u>Length of Stay/Average:</u> TH and SSO Only - Average length of stay for leavers	APR pulled from HMIS; APR from DV providers	• Less than 9 months (274 days or less) = 1 point • 9 - 12 months (275 to 365 days) = 0.5 points
5	<u>Length of Stay/Less than 12 months:</u> TH and SSO Only - The percentage of participants whose length of stay is 12 months or less	APR pulled from HMIS; APR from DV providers	• 90%+ = 1 point • 80-89% = 0.5 points
6 Not scored in 2026	<u>Length of time between Project Start Date and Housing Move-in Date (RRH, TH-RRH, and PSH only)- Average</u> 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) <i>This criterion will be evaluated in 2025 but will not be scored.</i> N/A for TH and SSO	APR pulled from HMIS; APR from DV providers	Target: 30 days or less (average) Not scored in 2026
7	<u>Increase in Total Income:</u> % 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. YHDP average outcomes in 2025: 27%	APR pulled from HMIS; APR from DV providers	• 30% or more had an increase in total income = 7 points • 25-29% increase income = 6 points • 20-24% increase income = 4 points • 15-19% increase income = 3 points
8	<u>Employment Income Growth:</u> 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) YHDP average outcomes in 2025: 23%		• 20%+ = 1 point • 10%+ = 0.5 points

9	Participants with any Income - % of adult participants with 1+ source of income at exit/annual assessment (leavers and stayers) YHDP average outcomes in 2025: 45%	APR pulled from HMIS; APR from DV providers	● 50%+ - 3 points ● 40-49% - 2 points ● 30-39% - 1 point
10	Participants Connected to Mainstream Benefits % of adult participants with 1+ source of Non-Cash benefits (SNAP, WIC, TANF, others, etc.) Average outcomes in 2025: 58%	APR pulled from HMIS; APR from DV providers	● 65% = 5 points ● 55-64% = 4 points ● 45-54% = 3 points ● 35-44% = 2 points
11	Participants Connected to Health Insurance: Percentage of all participants with 1+ source of health insurance YHDP average outcomes in 2025: 82%	APR pulled from HMIS; APR from DV providers	● 85%+ - 4 points ● 75-84% - 3 points ● 65-74% - 2 points ● 55-64% - 1 point
12	High Quality Data Entry: % 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 ● 11.a. – 0% error rate – 0.5 points ● 11.b.– 0% error rate – 0.5 points ● 11.c. – 0% error rate – 0.5 points ● 11d.– 0% error rate – 1.5 points ● 11e.– 0% error rate – 1.5 points ● 11.f. – 0% error rate – 1.5 points ● 11.g. – 0% error rate – 1.5 points

13	<u>Timeliness of Data Entry</u> <u>a. % of project entry records entered into HMIS (or DV comparable database) within 10 days</u> <u>b. % of project exit records entered into HMIS (or DV comparable database) within 10 days</u> 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. This criterion evaluates whether data was entered within 10 days. 2025 YHDP Average Outcomes Entries: 84% 2025 YHDP Average Outcomes Exits: 89%	APR pulled from HMIS; APR from DV providers	4 points total a. Entry records • 100% of project entry records input within 0-10 days – 2 points • 90% of project entry records within 0-10 days – 1.5 points • 80% of project entry records input within 0-10 days – 1 point • 70% of project entry records within 0-10 days – 0.5 points b. Exit records • 100% of project exit records input within 0-10 days - 2 points • 90% of project exit records within 0-10 days – 1.5 points • 80% of project exit records input within 0-10 days – 1 point • 70% of project exit records within 0-10 days – 0.5 points
Grant Management/Monitoring = 15 points PSH/RRH/TH-RRH/TH; 12 points SSO			
14	<u>Participant Eligibility:</u> % of heads of household (entering the project during the data lookback period) whose prior living situation was reported as literally homeless situations or fleeing DV Prior residence of adult participants 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-threatening conditions that relate to violence against the individual or family member)	APR validation file (HMIS-participating projects) and RSF data	• 100% of adult heads of household served were literally homeless/fleeing DV = 2 points • 94-99% of adult heads of household served were literally homeless/fleeing DV = 1 points

	If agencies enrolled heads of household who entered via a project transfer, this will need to be reported to DMA via the Renewal Summary Form process.		
15	Unit Utilization: Average utilization/occupancy rate of project Average utilization rate of project (using project utilization each quarter, as reported on APR) • N/A for SSO (SSO projects are not scored on this criterion; however, SSO projects will be evaluated on utilization compared to renewal application and if there are concerns with utilization those will be raised with the Funding Committee and/or YAB). For projects with under 10 units, will use a 3-year average if the project is under 80% utilization. 2025 YHDP Average: 87%	# units per 2025 renewal app compared to average unit utilization; APR pulled from HMIS; APR from DV providers	• 90+ utilization rate = 3 points • 85-89% = 2 points • 80-84% = 1 point
16	Funds Expended: % of grant funds expended. Ensure project is fully utilizing CoC funding. Goal = full spend down If less than 90% expended, grantee will be asked to submit a supplemental form related to grant spending over last 3 years and projected spending. 2025 YHDP Average: 94%	e-LOCCS and/or Sage data	• 100% of funds expended = 8 points • 95% - 99% expended = 6 points • 90% - 94% expended = 2 points • <90% expended = 0 points
17	Timely APR submission APR submitted within 90 days of end of grant (HUD requirement)	Last submitted APR (Sag)	• Timely submission = 2 points • Submitted beyond 90 days = 0 points
HUD/CoC Priorities = 2 points			
18	Lived Experience on Board • Grantee has a minimum of one homeless individual or formerly homeless individual on the board of directors or other equivalent policymaking entity of the recipient or subrecipient OR grantee has received HUD approval for a plan to otherwise consult with homeless	Renewal Summary Form	Maximum 2 points • Organization affirms that they have a homeless individual or formerly homeless individual on the board of directors = 2 points

	or formerly homeless individuals when considering and making policies and decisions. This is a HUD requirement per CoC Interim Rule Section 578.75(g).		OR • Organization shows documentation that HUD has approved an alternate plan for involving individuals with lived experience in decision-making = 2 points • Org does not meet above requirement = 0 points
24 (added)	<u>Service Participation</u> CoC grantee requires participation in services in alignment with CoC and HUD requirements, except where prohibited by federal law.	CoC monitoring records	2 points for submission of service participation requirement.
CoC Participation = 12 points PSH/RRH/TH-RRH/TH/SSO			
19	<u>CoC meetings</u> • CoC Meeting Attendance. Full participation in CoC is expected in order to further the goals of the CoC. ■ For projects with one or more subrecipients, expectation is that recipient AND 50% or more of all subrecipients must attend CoC meeting to receive points. ■ Grantees will be asked to provide a list of all subrecipients as part of the Renewal Summary Form. 2025 Full CoC Meeting Dates: 3/19/25 (in person), 9/3/25 (in person), 12/17/25 (virtual)	RSF & CoC meeting sign-in sheets and/or Zoom records	2 total points • Attendance at 2 out of 3 CoC meetings (or more) - 2 points • Attendance at 1 out of 3 CoC meetings – 1 point • Attendance at 0 CoC meetings – 0 points
20a	<u>Regional Homeless Advisory Board (RHAB) meetings</u> • Participation in RHAB meeting (Southwest RHAB) or Northwest Housing Collaborative Meeting (Northwest RHAB). 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 50% or more RHAB meetings in all RHABs they serve.	RSF & RHAB attendance sheets and/or Zoom records	• Attended at least 50% of all RHAB or Northwest Housing Collaborative meetings in 2025 = 2 points • Projects serving more than 1 RHAB will be able to earn a maximum of 4 points on this criteria, as they are excluded from LHOT criteria.

	Grantees will be asked to provide a list of all subrecipients as part of the Renewal Summary Form.		
20b	<u>County LHOT or housing coalition meetings</u> Participation in county LHOT or Housing Coalition Meetings. Full participation in county LHOT or housing coalition meetings is expected in order to further the goals of the CoC. NOTE: Projects serving more than 1 RHAB are EXCLUDED from LHOT criteria. Projects serving more than 1 RHAB will be able to earn a maximum of 4 points on the RHAB criteria.	Letter signed by Chair of county entity	Attendance at 75% or more of all county LHOT/housing coalition meetings = 2 points
21	<u>Participation in CoC Training Events</u> Full participation in webinar and training opportunities is expected of all CoC funded organizations - For projects with one or more subrecipients, expectation is that, at a minimum, 50 % or more of all subrecipients must attend CoC training to receive points. - Recipient is strongly encouraged to also attend trainings. - Grantees will be asked to provide a list of all subrecipients as part of the Renewal Summary Form. - Grantees are strongly encouraged to attend trainings live. However, for virtual trainings watching recorded trainings does count toward attendance. Attendee MUST submit an attendance survey to document that they watched the training.	RSF & Attendance sheets and/or Zoom records	Attendance at CoC training events is expected of organizations receiving CoC funding. Maximum Points – 6 points 2025 required trainings: - Fair Housing, Equal Access and Landlord/Tenant Law Training – 5/12/25 webinar – 1 point - Mainstream Benefits Training (PA DHS Mainstream Benefits and Programs) – 5/19/25 webinar – 1 point - West Written Standards Training Part 1 – 3/13/25 webinar – 1 point - West Written Standards Training Part 2 – 3/26/25 webinar – 1 point - Best practices in Housing Retention Training (for RRH and PSH) – Training offered 6/2/25, 6/3/25, 6/4/25, 6/5/25. – 2 points

22	<u>Coordinated Entry Participation</u> • Participation in Case Conferencing • Record Referral Outcomes for All HMIS Referrals (N/A for Victim Service Providers) ○ N/A for SSO projects Note: YHDP projects not scored on 100% Enrollments through CE, as the referral/enrollment process differs slightly for YHDP projects based on YHDP Written Standards. In future years, the CoC also plans to evaluate grantees 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	1 point total • 22a. CE case conferencing – 75%+_ attendance at case conferencing meetings – 0.5 points • 22b. – N/A for YHDP • 22c. 100% Referral outcomes logged in HMIS – 0.5 points (N/A for VSPs)
23	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 = 74.5 points
- TH = 76.5
- SSO = 71.5 points

*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

Criteria #	Criteria	Calculation
1a	TH/SSO/TH-RRH – HOUSING STABILITY TH Measurement: % of participants/leavers who exited to permanent housing destination among those who exited project. SSO Measurement: % of participants/leavers who were placed into Emergency Shelter, Transitional Housing or Permanent Housing <u>TH-RRH RRH Measurement</u>: % of participants/leavers who exited to permanent housing destination among those who exited project.	TH 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) SSO Q23c: Exit Destination <u>Numerator</u>: (Q23c-Total persons exiting to permanent housing destinations) + (Q23c-Total persons exiting to temporary housing destinations) + (Q23a – Total persons exiting to 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) TH-RRH APR Q23c: Exit Destination <u>Numerator</u>: (Q23c-Total persons exiting to positive housing destinations) + (Q23c-Transitional housing) <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	PSH- HOUSING STABILITY	

	PSH Measurement: % of participants/stayers who remained in PSH project or participants/leavers who exited to other permanent housing.	PSH: APR Q1 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) <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
2	RETURNS TO HOMELESSNES % of adults return to homelessness within 6 months of program exit to a permanent housing destination <i>N/A for DV providers</i>	SPM 2ab Data File – Returns to Homelessness <u>Numerator:</u> # of Adults who returned to an ES, TH or SH projects within 6 months of Exit to Permanent Housing <u>Denominator:</u> # Clients who exited from program to a permanent housing destination between 7/1/24-12/31/25
3	DV-DEDICATED PROJECTS - QUARTERLY MONITORING	CoC records of submission of APR data on a quarterly basis, by stated deadline
4	LENGTH OF STAY/AVERAGE (TH AND SSO ONLY) Average length of stay for leavers	APR Q22b: Average and Median Length of Participation in Days Average Length-Leavers
5	LENGTH OF STAY/LONGER THAN 12 MONTHS (TH AND SSO ONLY) The percent of participants whose length of stay is 12 months or less	APR Q22a1: Length of Participation – CoC Projects <u>Numerator:</u> (Total-30 days or less) + (Total-31 to 60 days) + (Total-61 to 90 days) + (Total-91 to 180 days) + (Total-181 to 365 days) <u>Denominator:</u> (Total-Total)

6 Not scored in 2025	LENGTH OF TIME BETWEEN PROJECT START DATE AND RESIDENTIAL MOVE IN	Q22c: Length of Time between Project Start Date and Housing Move-in Date Average length of time to housing: Total Not scored in 2025
7	INCREASE IN 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)
8	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)
9	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)
10	CONNECTING PARTICIPANTS TO MAINSTREAM BENEFITS Percent 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)
11	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) <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)
12	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/Ethnicity d. Destination e. Income and Sources at Entry	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/dating violence/sexual assault/human trafficking/stalking survivor not

	f. Income and Sources at Annual Assessment g. Income and Sources at Exit	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 f (Income and Sources at Entry) and projects with no exits won't be scored on e (Destination) and h (Income and Sources at Exit)
13	TIMELINESS OF HMIS DATA ENTRY a. % of project entry records entered into HMIS within 10 days b. % of project exit records entered into HMIS within 10 days	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 12.a. Projects with no exits won't be scored on 12.b.
14	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	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 adult heads of household whose prior living situation was literally homeless OR participant reports currently fleeing DV.

		Numerator: # of heads of household enrolled between 1/1/25-12/31/25 who were literally homeless and/or fleeing DV at project entry Denominator: Total # of heads of household enrolled between 1/1/25-12/31/25 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
15	UNIT UTILIZATION RATES Average utilization/occupancy rate of project (using project utilization each quarter, as reported on APR) (N/A for SSO)	Information provided in the Renewal Project Summary Form survey will be considered in calculating utilization. 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 80% utilization.
16	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.
17	TIMELY APR SUBMISSION	Review of Sage data

	APR submitted within 90 days of end of grant	
18	LIVED EXPERIENCE ON BOARD	Review of RSF information submitted by agency
19	COC MEETINGS CoC Meeting Attendance	Review of RSF documentation submitted by agency, meeting sign in records, and online survey attendance submissions
20a	REGIONAL HOMELESS ADVISORY BOARD (RHAB) MEETINGS Participation in RHAB meetings	Review of RSF documentation submitted by agency, sign in records submission from RHAB meetings, and documentation from RHAB chairs
20b	COUNTY LHOT OR HOUSING COALITION MEETINGS Participation in county LHOT or Housing Coalition Meetings	Review of RSF documentation submitted by agency, sign in records from LHOT meetings, and documentation from LHOT chairs
21	PARTICIPATION IN COC TRAINING EVENTS	Review of RSF documentation submitted by agency, webinar/training sign in records, and online survey attendance submissions
22	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
2	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 Western 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".

Western 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				

Western 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				

Western 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		

Western 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 to 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		

Western 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		

Western 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	

Western 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						

Western 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	

Western 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	

Western 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		

Western 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			

Western 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	

Western 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		

Western 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				

Western 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					

Western 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.					

Western 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.		

Western 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.		

Western 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).		

Western 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-601 – Western 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-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Warren-Forest EOC	PA0777 - Youngsville Permanent Supportive Housing	PSH	99.5	Accepted	1	\$62,932	
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge	PSH	99.4	Accepted	2	\$28,358	
Warren-Forest EOC	PA0897 - Warren Permanent Supportive Housing	PSH	99.3	Accepted	3	\$68,859	
Crawford County Mental Health Awareness Program, Inc	PA0460 - CHAPS Family Housing	PSH	98.9	Accepted	4	\$222,930	
Crawford County Mental Health Awareness Program, Inc	PA0495 - Housing Now	PSH	97.2	Accepted	5	\$244,341	
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care	PSH	96.1	Accepted	6	\$248,837	
Lawrence County Social Services, Inc.	PA0304-NWRHA	PSH	96.1	Accepted	7	\$493,976	
Crawford County Mental Health Awareness Program, Inc	PA1101 - Liberty House PSH	PSH	95.1	Accepted	8	\$140,324	
Northern Cambria Community Development Corporation	PA0491 Chestnut Street Gardens PSH	PSH	94.8	Accepted	9	\$161,437	
Lawrence County Social Services, Inc.	PA0425-Turning Point	PSH	93.8	Accepted	10	\$298,684	
County of Butler	PA0290 Path Transition Age Project	PSH	92.4	Accepted	11	\$128,557	

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Fayette County Community Action Agency, Inc.	PA0616-Fayette Apartments	PSH	91.5	Accepted	12	\$149,089	
County of Butler	PA0539 Home Again Butler County	PSH	88.4	Accepted	13	\$257,924	
Victim Outreach Intervention Center	PA0280-VOICe-EnduringVOICe2024	PSH	87.2	Accepted	14	\$454,691	
CAPSEA, Inc.	PA0311 Housing Plus	PSH	87.1	Accepted	15	\$165,146	
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons	PSH	86.4	Accepted	16	\$129,775	
County of Butler	PA0287 HOPE Project	PSH	85.7	Accepted	17	\$250,353	
Westmoreland Community Action	PA0600 - WCA PSH	PSH	84.8	Accepted	18	\$726,077	
Indiana County Community Action Program, Inc.	PA0599 PHD Consolidated FY2026	PSH	84.7	Accepted	19	\$136,355	
Fayette County Community Action Agency, Inc.	PA0560-Fairweather Lodge Supportive Housing	PSH	84.7	Accepted	20	\$31,977	
County of Washington	PA0291 - Permanent Supportive Housing	PSH	83.2	Accepted	21	\$1,315,596	
Greene County Human Services	PA0651-Greene County Shelter Plus Care Project	PSH	83.1	Accepted	22	\$66,621	
Cameron/Elk Counties Behavioral & Developmental Programs	PA0307-AHEAD	PSH	83	Accepted	23	\$232,588	
Greene County Human Services	PA0538-Greene County Supportive Housing Project	PSH	82	Accepted	24	\$234,164	
County of Washington	PA0296 - Shelter plus Care	PSH	81.9	Accepted	25	\$290,851	
Community Connections of Clearfield/Jefferson Counties	PA0459 Housing First	PSH	80.7	Accepted	26	\$234,633	

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Armstrong County Community Action of Pennsylvania	PA0274 - Armstrong County Permanent Supportive Housing Program	PSH	80.5	Accepted	27	\$171,263	
Connect, Inc.	PA0904-DWEL	PSH	79.6	Accepted	28	\$731,725	
Community Services of Venango County, Inc.	PA0424 Sycamore Commons	PSH	76.3	Accepted	29	\$82,499	
Union Mission of Latrobe, Inc.	PA0540 - Union Mission Permanent Supportive Housing	PSH	75.9	Accepted	30	\$341,222	
Housing Authority of the County of Butler Inc.	PA0493 - Franklin Court Chronically Homeless	PSH	61.3	Accepted	31	\$62,611	
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care	PSH	No score - Project has not operated long enough to be scored yet.	Accepted	32	\$393,392	
Crisis Shelter of Lawrence County	PA1151 Arise DV PSH Project	PSH	No score - Project has not operated long enough to be scored yet.	Accepted	33	\$196,926	
Crawford County Mental Health Awareness Program, Inc	PA1053-Connections	SSO	94.8	Accepted	34	\$179,454	
Crawford County Mental Health Awareness Program, Inc	PA1055-Passages	PSH	94.5	Accepted	35	\$246,013	
Crawford County Mental Health Awareness Program, Inc	PA1054-Open Doors	SSO	81.7	Accepted	36	\$153,819	

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Westmoreland Community Action	PA1056 WCA Host Home	SSO	79	Accepted	37	\$219,831	
Westmoreland Community Action	PA1058 Westmoreland County Systems Navigation	SSO	77	Accepted	38	\$324,184	
Westmoreland Community Action	PA1059 YHDP WCA TH	TH	73.7	Accepted	39	\$469,795	\$469,795
Westmoreland Community Action	PA1057 WCA Regional Systems Navigation	SSO	71.8	Accepted	40	\$363,029	
Pennsylvania Coalition Against Domestic Violence	PA0980 - West CoC Regional DV RRH FY26 Renewal	RRH	57.4	Accepted	41	\$4,666,639	
Lawrence County Social Services, Inc.	PA0314-SAFE	SSO	90.5	Accepted	42	\$45,199	
Commonwealth of Pennsylvania	PA0428 Commonwealth of PA HMIS (PA-601) FY2026	HMIS	CoC infrastructure project - not competitively scored	Accepted	43	\$259,022	
Union Mission of Latrobe, Inc.	PA0940-DV Coordinated Entry Capacity	SSO-CE	CoC infrastructure project - not competitively scored	Accepted	44	\$213,316	
Union Mission of Latrobe, Inc.	PA1099 - Western PA Coordinated Entry	SSO-CE	CoC infrastructure project - not competitively scored	Accepted	45	\$1,032,292	
Crawford County Mental Health Awareness Program, Inc	PA0562 - CHAPS Fairweather Lodge Expansion	PSH (Services Expansion)	99.4	Accepted	46	\$27,161	
Crawford County Mental Health Awareness Program, Inc	PA0309 - Crawford County Shelter plus Care Expansion	PSH (Services Expansion)	96.1	Accepted	47	\$40,842	

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
County of Butler	PA0539 Home Again Butler County Expansion	PSH (Services Expansion)	88.4	Accepted	48	\$14,378	
Victim Outreach Intervention Center	PA0280-VOICe-Enduring VOICe Expansion	PSH (Services Expansion)	87.2	Accepted	49	\$54,897	
Clarion County Housing Authority	PA0310 Housing for Homeless and Disabled Persons Expansion	PSH (Services Expansion)	86.4	Accepted	50	\$48,444	
CAPSEA, Inc.	PA0458 DuBois Housing Authority Shelter Plus Care Expansion	PSH (Services Expansion)	84.5	Accepted	51	\$27,500	
County of Washington	PA0296 - Shelter plus Care Expansion	PSH (Services Expansion)	80.1	Accepted	52	\$64,551	
Lawrence County Social Services, Inc.	PA0901-My First Place Youth Transitional Housing	TH	96.8	Accepted	53	\$257,308	\$257,308
Lawrence County Social Services, Inc.	PA-0775-TEAM Youth Transitional Housing	TH	96.6	Accepted	54	\$96,752	\$96,752
Armstrong County Community Action of Pennsylvania	PA0776 Transitional Housing Program of Armstrong County	TH	88	Accepted	55	\$175,742	\$175,742
Lawrence County Social Services, Inc.	PA-0718-Veterans Transitional Housing	TH	87.5	Accepted	56	\$93,515	\$93,515
Crisis Shelter of Lawrence County	PA0939-Arise TH Operating	TH	85.2	Accepted	57	\$262,325	\$262,325

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Armstrong County Community Action of Pennsylvania	PA0716 - Family Transitional Housing Program of Armstrong County	TH	85.1	Accepted	58	\$119,424	\$119,424
Fayette County Community Action Agency, Inc.	PA0846-FCCAA Transitional Housing Program	TH	83.4	Accepted	59	\$1,445,587	\$1,445,587
Greene County Human Services	PA0780 Greene County Transitional Housing Project	TH	76.8	Accepted	60	\$225,465	\$225,465
County of Washington	PA1048 Washington Transitional Project	TH	76.5	Accepted	61	\$871,151	\$871,151
McKean County Redevelopment & Housing Authorities	PA0778- Northwest Transitional Housing	TH	49.1	Accepted	62	\$1,106,654	\$771,788
County of Washington	PA1150 - Washington County SWPA Transitional Housing	TH	No score - Project has not operated long enough to be scored yet.	Accepted	63	\$752,468	\$752,468
Pennsylvania Coalition Against Domestic Violence	PA1149 FY26 New Western PA DV TH	TH	No score - Project has not operated long enough to be scored yet.	Accepted	64	\$4,037,537	\$4,037,537
Pennsylvania Coalition Against Domestic Violence	PA1191 FY26 New Western PA DV TH - 2	TH	No score - Project has not operated long enough to be scored yet.	Accepted	65	\$2,505,282	\$2,505,282
Warren-Forest EOC	Warren Forest EOC SSO Standalone	SSO	99.4	Accepted	66	\$59,754	\$0
Crawford County Mental Health Awareness Program, Inc	CHAPS Horizons	SSO	97	Accepted	67	\$366,055	\$234,408

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Lawrence County Social Services	Foundations-SSO	SSO	93.5	Accepted	68	\$419,870	\$0
County of Butler	Butler County Housing Support Program	SSO	88.8	Accepted	69	\$143,500	\$0
Crisis Shelter of Lawrence County	Arise TH - Leasing	TH	85.2	Accepted	70	\$1,056,253	\$0
Westmoreland Community Action	Adult Regional TH - Recovery Focused	TH	84.8	Accepted	71	\$941,000	\$0
The Lighthouse Foundation	Lighthouse Foundation Transitional Housing	TH	80	Accepted	72	\$247,000	\$0
Westmoreland Community Action	Adult Regional TH	TH	84.8	Accepted	73	\$941,000	\$0
CAPSEA, Inc.	Housing Plus Pathways	TH	87.1	Accepted	74	\$335,544	\$0
Commonwealth of Pennsylvania	2026 CoC Planning Grant	Planning	CoC Planning Grant not scored/ not ranked	Accepted	Not Ranked	\$1,438,802	
Armstrong County Community Action of Pennsylvania	PA0716 - Armstrong-Fayette Rapid Rehousing Program	PH-RRH	85.1	Fully Reallocated	Not Ranked	\$0	(\$119,424)
Armstrong County Community Action of Pennsylvania	PA0776 - Rapid Rehousing Program of Armstrong County	PH-RRH	88	Fully Reallocated	Not Ranked	\$0	(\$175,742)
Greene County Human Services	PA0780-Greene County Rapid Rehousing Project	PH-RRH	76.8	Fully Reallocated	Not Ranked	\$0	(\$225,465)
County of Washington	PA1048 - Washington County Rapid Rehousing One	PH-RRH	76.5	Fully Reallocated	Not Ranked	\$0	(\$871,151)

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
County of Washington	PA1150 - Mon Valley Collaboration	Joint TH-RRH	No score - Project has not operated long enough to be scored yet.	Fully Reallocated	Not Ranked	\$0	\$ (752,468.00)
Crawford County Mental Health Awareness Program, Inc	PA0308 - Crawford County Housing Advocacy Project	SSO	93	Fully Reallocated	Not Ranked	\$0	(\$104,335)
Crisis Shelter of Lawrence County	PA0939-Arise Joint TH/RRH	Joint TH-RRH	85.2	Fully Reallocated	Not Ranked	\$0	\$ (262,325.00)
Fayette County Community Action Agency, Inc.	PA0846-Fayette County Rapid Rehousing	PH-RRH	83.4	Fully Reallocated	Not Ranked	\$0	\$ (1,445,587.00)
Lawrence County Social Services, Inc.	PA0718-Veterans RRH	PH-RRH	87.5	Fully Reallocated	Not Ranked	\$0	\$ (93,515.00)
Lawrence County Social Services, Inc.	PA0775-TEAM RRH	PH-RRH	96.6	Fully Reallocated	Not Ranked	\$0	\$ (96,752.00)
Lawrence County Social Services, Inc.	PA0901-My First Place	PH-RRH	96.8	Fully Reallocated	Not Ranked	\$0	\$ (257,308.00)
McKean County Redevelopment & Housing Authorities	PA0778- Northwest Rapid RRH Combined	PH-RRH	49.1	Fully Reallocated	Not Ranked	\$0	\$ (771,788.00)
Pennsylvania Coalition Against Domestic Violence	PA1149 FY 24 NEW Western PA CoC DV RRH	PH-RRH	No score - Project has not operated long enough to be scored yet.	Fully Reallocated	Not Ranked	\$0	\$ (4,037,537.00)

PA-601 CoC: 1D-2c. Local Competition Selection Results

Applicant Name	Project Name	Project Type	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Pennsylvania Coalition Against Domestic Violence	PA1191 FY24 NEW Western PA CoC DV RRH Expansion	PH-RRH	No score - Project has not operated long enough to be scored yet.	Fully Reallocated	Not Ranked	\$0	\$ (2,505,282.00)
Union Mission of Latrobe, Inc.	Western PA CoC Street Outreach	SSO		Rejected	Not Ranked	\$0	\$0
Westmoreland Community Action	PA0283 - Gallatin School Living Centre	TH	No score - Project has not operated long enough to be scored yet.	Fully Reallocated	Not Ranked	\$0	(\$130,073)
Westmoreland Community Action	PA1059 YHDP WCA TH-RRH Renewal	Joint TH-RRH	73.7	Fully Reallocated	Not Ranked	0	(\$469,795)

\$0

FY 2026

PA-601 – Western Pennsylvania

Continuum of Care

2A-8b. FY 2026 HDX Competition Report

Documents include the following:

- **PA-601 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-601 - Western 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-601 - Western 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-601 - Western 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	1,358	44.9	33.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	1,518	61.4	36.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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”)	1,874	132.7	61.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	2,023	141.2	65.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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	32	0	0.0%	1	3.1%	1	3.1%	2	6.3%
Exit was from ES	627	28	4.5%	29	4.6%	38	6.1%	95	15.2%
Exit was from TH	121	2	1.7%	3	2.5%	2	1.7%	7	5.8%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	815	29	3.6%	14	1.7%	28	3.4%	71	8.7%
TOTAL Returns to Homelessness	1,595	59	3.7%	47	3.0%	69	4.3%	175	11.0%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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	1,529
Emergency Shelter Total	1,360
Safe Haven Total	0
Transitional Housing Total	189

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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)	385
Number of adults with increased earned income	59
Percentage of adults who increased earned income	15.3%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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)	385
Number of adults with increased non-employment cash income	123
Percentage of adults who increased non-employment cash income	32.0%

Metric 4.3 – Change in total income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	385
Number of adults with increased total income	172
Percentage of adults who increased total income	44.7%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	521
Number of adults who exited with increased earned income	136
Percentage of adults who increased earned income	26.1%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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)	521
Number of adults who exited with increased non-employment cash income	126
Percentage of adults who increased non-employment cash income	24.2%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	521
Number of adults who exited with increased total income	252
Percentage of adults who increased total income	48.4%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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.	1,389
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.	186
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)	1,203

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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.	2,309
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.	324
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.)	1,985

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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	192
Of persons above, those who exited to temporary & some institutional destinations	50
Of the persons above, those who exited to permanent housing destinations	70
% Successful exits	62.5%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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	1,723
Of the persons above, those who exited to permanent housing destinations	1,260
% Successful exits	73.1%

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	1,303
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	1,272
% Successful exits/retention	97.6%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-601 - Western 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)	1,392	191	1,406	1,412	195
Total Leavers (HMIS)	1,257	110	428	848	132
Destination of Don't Know, Refused, or Missing (HMIS)	27	8	0	12	23
Destination Error Rate (Calculated)	2.2%	7.3%	0.0%	1.4%	17.4%

2025 HDX Competition Report

2026 Competition Report - SPM Notes

PA-601 - Western 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-601 - Western 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	819	256	629	0	629	40.7%
SH	0	0	0	0	0	NA
TH	280	105	270	0	270	38.9%
RRH	794	515	515	0	515	100.0%
PSH	1,186	902	1,039	0	1,039	86.8%
OPH	122	28	122	40	82	34.1%
Total	3,201	1,806	2,575	40	2,535	71.2%

2025 HDX Competition Report

2026 Competition Report

PA-601 - Western 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	819	190	190	0	190	100.00%
SH	0	0	0	0	0	NA
TH	280	10	10	0	10	100.00%
RRH	794	279	279	0	279	100.00%
PSH	1,186	147	147	0	147	100.00%
OPH	122	0	0	0	0	NA
Total	3,201	626	626	0	626	100.00%

2025 HDX Competition Report

2026 Competition Report

PA-601 - Western 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	819	446	819	54.46%
SH	0	0	0	NA
TH	280	115	280	41.07%
RRH	794	794	794	100.00%
PSH	1,186	1,049	1,186	88.45%
OPH	122	28	82	34.15%
Total	3,201	2,432	3,161	76.94%

2025 HDX Competition Report

2026 Competition Report - HIC Summary

PA-601 - Western 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-601 - Western 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	564	605	597
Safe Haven Total	0	0	0
Transitional Housing Total	161	183	188
Total Sheltered Count	725	788	785
Total Unsheltered Count	49	89	75
Total Sheltered and Unsheltered Count*	774	877	860

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	33	55	87
Total Unsheltered Count	6	15	3
Total	39	70	90

FY 2026

PA-601 – Western Pennsylvania

Continuum of Care

**3A-DP. Your CoC's Policy or Statement to
Advance Recovery**

Documents include the following:

- **Western PA CoC Policy on Illicit Drug Enablement**



Western PA CoC Policy on Illicit Drug Enablement

Approved by Western PA CoC Governing Board, 9-24-26

Policy

The Western 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 Western 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.