

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: AZ-502 - Phoenix, Mesa/Maricopa County CoC

1A-2. Collaborative Applicant Name: Maricopa Association of Governments

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Solari Crisis and Human Services

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	6
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	2
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	1
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	2
9.	Faith-based Organization(s)	Yes	1
10.	Homeless or Formerly Homeless Person(s)	Yes	2
11.	Hospital(s)	No	
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)	No	
14.	Law Enforcement	Yes	2
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	4
16.	Local Government Staff/Official(s)	Yes	4

17.	State Government Staff/Official(s)	Yes	1
18.	State or Local Elected Public Official(s)	Yes	3
19.	Local Jail(s)	Yes	1
20.	Mental Health Service Organization(s)	Yes	3
21.	Mental Illness Advocate(s)	Yes	1
22.	Organization(s) led by and serving people with disabilities	Yes	0
23.	Other homeless subpopulation advocate(s)	Yes	2
24.	Other nonprofit homeless assistance provider(s)	Yes	6
25.	Other social service provider(s)	Yes	4
26.	Public Housing Agencies	Yes	4
27.	Recovery Housing or Sober Living Provider(s)	Yes	1
28.	School Administrators/Homeless Liaison(s)	Yes	0
29.	School District(s)	No	
30.	Street Outreach Team(s)	Yes	3
31.	Substance Abuse Advocate(s)	Yes	1
32.	Substance Abuse Service Organization(s)	Yes	2
33.	Universities	Yes	1
34.	Veteran Serving Organization(s)	Yes	4
35.	Agencies Serving Survivors of Human Trafficking	Yes	3
36.	Victim Service Provider(s)	Yes	2
37.	Domestic Violence Advocate(s)	Yes	1
38.	Other Victim Service Organization(s)	Yes	0
39.	State Domestic Violence Coalition	Yes	1
40.	State Sexual Assault Coalition	Yes	1
41.	Youth Advocate(s)	Yes	1
42.	Youth Homeless Organization(s)	Yes	0
43.	Youth Service Provider(s)	Yes	0
44.	Other Homeless Assistance Provider(s)	Yes	0
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	1
	Other: (limit 50 characters)		
46.	Philanthropic Organizations	Yes	2
47.	Regional Behavioral Health Authority (RBHA)	Yes	1

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. The Maricopa Regional Continuum of Care (CoC) provides a transparent and publicly available solicitation for new members to apply for seats on the CoC Board and its committees at least once each year. The Collaborative Applicant posts the invitation on its website and advertises the opportunity through the CoC's weekly newsletter, ensuring that people across the region can view the opportunity without needing to contact staff or access internal networks. The notice explains how the annual Board and Committee recruitment process is conducted, outlines current committee openings, and provides clear instructions for submitting an interest form. Recruitment for General Membership is open continuously, with notices available on the CoC website and shared weekly on the CoC's newsletter. Collaborative Applicant staff supply information regarding General Membership to any organizations, individuals, and systems seeking to join, partner, or coordinate with the CoC.

B. To ensure broad access, the CoC distributes the annual Board and Committee recruitment invitation through its public email list, which includes over 2,200 service providers, healthcare partners, outreach teams, housing programs, faith-based organizations, schools, and other community stakeholders. The CoC also shares the notice through regional meetings open to the public. This approach ensures that participants, partners, and community members can review the invitation in formats that are easy to access and understand. Additionally, the CoC distributes weekly newsletters electronically which provide detailed information on any available funding opportunities, policy changes, and opportunities to participate in the CoC.

The invitation process uses plain language and provides step-by-step descriptions of how potential members can participate. The Collaborative Applicant ensures the process is consistent year-over-year, so interested organizations and individuals know where and when to find the information. The CoC also makes the invitation available in accessible electronic formats to support fair access for people who use assistive technology.

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.
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(limit 2,500 characters)

A. The CoC uses a transparent and publicly available process to gather and consider feedback on its overall performance, system strategies, and annual priority setting activities. The Collaborative Applicant posts information about public meetings, comment opportunities, and participation methods on its website so people across the region can review these details without needing direct outreach or staff contact. Posted meeting materials include agendas and minutes.

The CoC invites input during open meetings for its Board and committees. These meetings include time for public comments and structured discussions where members and guests can share observations and ask for more information about system operations, resource needs, and performance trends. Meeting materials, agendas, and summaries are posted online in accessible formats so participants can track the issues under review and understand how feedback is used. The CoC also uses surveys and regional forums to collect information from individuals who prefer electronic participation.

In addition, the CoC maintains a standardized process to allow those served by CoC-funded projects to submit grievances. The Collaborative Applicant reviews submitted grievances, documents findings, and coordinates follow up with the agency involved to ensure a timely response and resolution. Reports on grievances are used to improve system performance and to inform the monitoring process.

B. The CoC considers input from a broad array of organizations and individuals with knowledge of homelessness or an interest in preventing or ending it. This includes public safety providers and law enforcement, healthcare partners, outreach teams, housing programs, faith-based organizations, education and research partners, public safety agencies, local jurisdictions, private sector and business representation, veteran service organizations, youth-serving providers, and people who have lived experience of the homelessness response system. These groups participate because of their operational knowledge, their role in connecting people to housing, or their interest in improving regional coordination through representation that leverages the strengths and assets of each sector.

The CoC's Board and Committees review the information collected through meetings, forums, and surveys and use it to guide performance discussions, refine strategies, and support priority decisions.

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)

A. The CoC uses a transparent and publicly posted process to accept and consider proposals from organizations that have not previously received CoC Program funding, including faith-based organizations. Each year, the Collaborative Applicant posts a notice on its website and weekly newsletter announcing the opportunity to submit proposals through the local competition. This notice explains the application timeline, access to the local submission portal, and the evaluation steps that occur before proposals are reviewed by the Rank and Review Committee. This year, the CoC expanded its outreach by issuing a press release.

The CoC accepts proposals through a standardized electronic submission process, providing clear instructions, an application guide, and access to technical assistance via webinars so new organizations can complete the required documents and understand how the local process works. These webinars are offered to new and returning applicants in the same formats. The CoC's Appeals Procedure provides a structured process for agencies to contest specific funding decisions if they believe the review process was not applied consistently. To appeal, agencies must submit a formal request within 48 hours of the CoC Board's decision, which is then evaluated by an independent Appeal Panel comprised of non-conflicted Board members. Recommendations from the Appeal Panel are approved by the CoC Board to create a publicly transparent final ruling. All materials are available in accessible electronic formats to support fair access for people who use assistive technology.

B. The CoC encourages submissions from organizations that have not previously received CoC funding. For this grant cycle, six first time applicants submitted proposals. If new proposals are received, they move through the same review steps as renewal projects. The Rank and Review Committee evaluates all applications using the local scorecards, which focus on measurable performance, capacity to support self-sufficiency, coordinated services, and alignment with HUD's recovery-oriented priorities.

If the CoC does not receive proposals from new organizations in a given year, the Collaborative Applicant conducts direct outreach to broaden participation. This outreach includes email announcements to regional partners, open informational sessions, and targeted communication with faith-based groups, healthcare partners, and community agencies that provide housing or recovery-focused services.

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)

The CoC Board oversees creation and implementation of the CoC strategic plan through a year-round process that identifies gaps, sets timelines, develops resources, and evaluates performance. Gaps are identified through HMIS and system data, provider and jurisdiction feedback, and an annual roundtable with law enforcement. Committees review input and develop annual work plans for Board approval. The Board directs committees, lead agencies, funded providers, and stakeholders to implement tasks and performance metrics and monitors progress throughout the year.

Key System Performance Goals by December 31, 2027, include: 1) reducing first-time homelessness by 5 percent and reducing Length of Time homeless to 108 days or less; and 2) increasing successful exits to housing to 41 percent with 97 percent retention.

Consistent with 42 U.S.C. 11386b(d), the Board directs strategies to strengthen system outcomes. These include partnering with philanthropy to evaluate system effectiveness; expanding emergency shelter and transitional housing capacity; increasing behavioral health and substance use treatment access across interventions; and improving homelessness prevention and diversion through philanthropic collaboration. Based on 2026 SPM reporting, first-time homelessness decreased 15 percent, positive exits reached 45 percent with 96 percent PSH retention, average ES stays dropped 5 percent to 113 days, earned income increased 2 percent, and local competition requests added 798 new TH units. The 2026 PIT Count showed a 15 percent decrease in unsheltered homelessness.

The Board is advancing HMIS improvements and data sharing to support these goals. In October 2026, new HMIS software will improve user experience, reporting, and integration. HMIS data sharing will expand to federal partners such as VA Medical Centers, local jurisdictions, and the Data Warehouse for Enterprise Linkages, which connects the three Arizona CoCs and the state Medicaid agency.

The Board also endorsed targeted subpopulation strategies, including coordination with VAMC surge efforts; working with philanthropic and family-serving providers to reduce shelter and housing waitlists for families; and continuing statewide Youth Homeless Systems Improvement work to build a regional youth plan, shared resources, and employment pathways, supporting the submission of a 2026 HUD YHDP request.

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

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

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

1C. Coordination and Engagement

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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?	32%

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)

N/A

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)

The CoC partners with outpatient treatment providers to ensure access to mental health and substance use treatment across multiple levels of care. Coordinated Entry and outreach teams make direct referrals and confirm appointments to maintain engagement. Circle the City, a Federally Qualified Health Center, provides outpatient primary and behavioral healthcare, medical respite for people recovering from acute conditions, and mobile and street medicine. Warm handoffs are arranged by outreach and hospital discharge for clinic follow-up and medications.

Recipients of CoC funding also provide robust treatment and recovery support for individuals experiencing homelessness. Community Bridges Inc (CBI) operates integrated behavioral health services that include outpatient counseling, medication management, peer support, crisis stabilization, and linkage to employment and housing resources. CBI also serves as the SAMHSA PATH contractor for Maricopa County, connecting unsheltered adults to screening, SMI determination, and treatment. Native American Connections provides intensive outpatient services for substance use and co-occurring needs through structured groups, case management, and peer coaching. Referrals are routed through Coordinated Entry.

For suicide prevention and urgent risk, the CoC uses the 988 crisis contact center operated by Solari for immediate safety planning and mobile crisis dispatch, followed by documented warm handoffs to outpatient providers.

To expand coverage and reduce uncompensated care, CoC-funded agencies and partners use Arizona Medicaid and the state Section 1115 waiver extension, which supports integrated managed care and links between housing and health services. Eligible Medicaid members can access covered behavioral health, crisis stabilization, peer support, transportation, and coordinated case management that help sustain participation in outpatient treatment. In addition, Arizona's Medicaid agency requires Managed Care Organizations, such as Mercy Care, the Regional Behavioral Health Authority, to participate in the CoC Board, Committees, and workgroups, to support system level integration between service providers and behavioral health services.

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)

The CoC ensures access to peer recovery specialists across crisis contact, outreach, outpatient, and housing navigation so participants receive coaching, accompaniment, and practical support from intake through stabilization. The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, requires that peer services be delivered by Peer and Recovery Support Specialists (PRSS) who complete an AHCCCS-recognized training and pass a competency exam, giving the CoC a standardized pathway to deploy credentialed peers across projects and partners.

The CoC's partnerships embed peers at critical engagement points. Community Bridges, Inc. (CBI) staffs 24/7 Peer Support Specialists and offers an AHCCCS-recognized PRSS certification course, expanding the regional workforce and strengthening navigation to treatment and housing. Solari's 988 crisis contact center deploys mobile crisis and arranges immediate safety planning, then routes stabilized callers to CE and peer-supported follow-up. La Frontera/EMPACT utilizes Peer Support Navigators who coordinate housing and employment pathways and document connections in HMIS or a comparable system, reinforcing continuity from court or crisis into services. Terros Health both employs peers within outpatient teams and provides an AHCCCS-approved peer certification program, creating a pipeline that sustains capacity for coaching, group support, and medication-adherence assistance.

Peers are embedded with CE navigators to meet participants at crisis sites, shelters, and clinics, complete CE referrals, schedule time-bound appointments, accompany participants to intakes, and confirm attendance. Warm hand-offs are documented and tracked to verify connection and address barriers. Medicaid-funded benefits administered by AHCCCS and contracted health plans finance these supports for eligible members, allowing peer teams to sustain engagement and reinforce treatment plans that promote stability and independence.

In the local competition, the scorecard recognizes formal peer partnerships and post-referral connection rates, which incentivize CoC-funded projects to expand peer staffing and deepen coordination with crisis, outpatient, and court-linked programs.

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 probable Serious Mental Illness (SMI) at crisis, street outreach, and Coordinated Entry (CE) touchpoints and immediately initiates Arizona's standardized SMI determination pathway. Providers submit the evaluation packet to the state-designated determining entity (Solari), which reviews it within three business days.

When SMI is designated, individuals are notified and connected to the ACC-RBHA health plan for the region (e.g., Mercy Care) and enrolled in integrated clinics ("integrated health homes - IHH") that coordinate behavioral and physical care, medications, case management, and peer supports.

Members who require intensive, mobile, and team-based care are linked directly to Assertive Community Treatment (ACT) teams. Mercy Care operates ACT teams as 24/7, multidisciplinary service for SMI members within the CoC.

If a person first presents through the crisis system, the CoC leverages its partnerships to ensure seamless hand-offs: Solari's 988 crisis contact center dispatches mobile crisis and routes stabilized callers to CE; RI International's Peoria Recovery Response Center offers 24/7 walk-in and first-responder drop-off with 23-hour observation, peer support, and care coordination that culminate in warm referrals to ongoing treatment (including ACT/IHH), housing navigation, and outpatient follow-up.

For SMI individuals with complex medical needs, the CoC coordinates medical respite and outpatient primary care via federally qualified health centers (e.g., Circle the City), with case conferencing to align psychiatric care plans, medications, and stabilization goals that support tenancy. If funded, Copa Pathways to Home new TH project will be located adjacent to the Arizona State Hospital and will accept individuals upon release from the hospital while also providing care coordination to and from Court Ordered Treatment.

All connections are reinforced by mainstream resources for efficient use of funding: the Medicaid system funds covered supportive services (e.g., case management, behavioral health, peer support, crisis stabilization, transportation to care), enabling continuity from crisis or outreach to ACT/IHH and housing services.

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)

The CoC coordinates closely with the City of Phoenix Public Defender's Office Community Court, Veterans Court, and Behavioral Health Court, and Keys to Change, which operates a monthly Homeless Court, to convert court referrals and orders into structured pathways for housing stability and independence. Partners jointly plan discharges, establish bidirectional referral protocols to CE and CoC-funded housing and services, and align treatment mandates with individualized service plans.

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

(limit 2,500 characters)

The CoC coordinates closely with the City of Phoenix Public Defender's Office (Community Court and specialty courts, including Veterans and Behavioral Health) and Keys to Change (monthly Homeless Court at Key Campus) to convert court referrals and orders into structured pathways for housing stability and independence. Court partners and the CoC jointly plan discharges, establish bidirectional referral protocols to Coordinated Entry (CE) and CoC-funded housing/services, and align treatment mandates with individualized service plans.

Operationally, court liaisons and CoC navigators meet participants at or immediately after court events, complete CE referrals, and schedule time-bound appointments for shelter placement, housing navigation, and behavioral health care; warm hand-offs are documented and tracked to confirm connection. The Public Defender's Office reports measurable results from court coordination (e.g., from January 2024: 251 program graduates; 411 participants connected to shelter or housing; 195 participants connected to mental health or substance use treatment), and commits to continued joint protocols for referral, discharge planning, and resource alignment across specialty courts. Keys to Change (CE Lead) maintains a monthly standing court docket at Key Campus with a court liaison and a staff advocate, reinforcing swift linkage from the courtroom to housing and supportive services.

To leverage court orders productively, the CoC incorporates ordered participation (e.g., outpatient care, case management check-ins, employment readiness) into service agreements and housing plans, then provides aggregate progress updates to court partners to support compliance and timely adjustments.

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 CoC partners with Solari, the 988-line operator, to integrate 988 crisis response for 24/7 stabilization, first-responder drop-offs, and warm hand-offs. The CoC also partners with Native American Connections, a CoC-funded agency, which provides integrated healthcare and mobile services supported by a broad provider network. The CoC convenes regional roundtables with CAP offices, law enforcement, and crisis partners to coordinate homelessness prevention and cross-system coordination.

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.	295
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)

The CoC has a formal partnership with Community Bridges, Inc., a CoC provider and Maricopa's PATH contractor, for outreach and SMI linkage to treatment. CBI's mental health centers include the Central City Addiction Recovery Center and Community Psychiatric Emergency Center. In addition, Arizona's Medicaid agency requires Managed Care Organizations to participate in the CoC, strengthening cross-system coordination.

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)

Community Bridges Inc. operates sober Transitional Housing through its Scattered Site TH and Rio TH programs. Additional sober housing projects include Copa Health's Pathways of Hope, City Help's Transitional Pathways of Success, and Maggie's Place's Recovery for Pregnant Moms Experiencing Homelessness program.

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)

Solari's 988 crisis contact center stabilizes callers and dispatches crisis response, then routes individuals to Coordinated Entry (CE); these transitions are documented and followed by scheduled housing navigation appointments to ensure continuity. RI International's Peoria Recovery Response Center accepts 24/7 walk-ins and first-responder drop-offs for crisis stabilization and care coordination, with immediate referrals back to CE and housing teams for housing plans and scheduled hand-offs.

Hospital and clinic connections use Circle the City's FQHC network, which includes medical respite, outpatient care, and mobile and street medicine, to bridge discharges and visits into CE and housing navigation; the signed letter of support commits to coordinated referrals, case conferencing, and follow-up to prevent homelessness after acute crisis episodes. For unsheltered adults with likely SMI, Community Bridges, Inc. serves as the county's PATH contractor, conducting outreach, screening/SMI determination, and linking individuals to treatment and housing resources through CE, which reduces missed connections and encampment returns. Copa Health coordinates discharges from treatment to its PSH projects, with clinical staff providing ongoing support to help participants maintain stability and long-term housing. The City of Phoenix Public Defender's Office aligns Community Court and other specialty court referrals with CE and treatment linkages, while Keys to Change (CE Lead Agency) operates a monthly Homeless Court docket at Key Campus with on-site advocacy to provide warm hand-offs and prevent jail-to-street cycles.

For older adult households, the CoC's partnership with Area Agency on Aging and MOU with Justa Center formalize warm referrals to residential and assisted-living options, set protocols to assess readiness, and remove barriers to permanent placements, including use of project-level preferences, when appropriate, to speed stable housing matches. The Area Agency on Aging runs the DOVES program, which assists survivors of late-life domestic violence, sexual assault, and elder abuse with case management, transitional housing, and more.

1C-2. Supportive Services Investment.

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$48,607,126
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.	\$11,717,062
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	24%
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.	\$15,802,907
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).	57%

1C-3.	Participation Requirements for Supportive Services.
	You must upload the Language from Project Supportive Service Agreements attachment to the 4A. Attachments Screen.
	What percent of your housing projects (TH, PH-PSH, PH-RRH, and Joint projects) require program participants to take part in supportive services (e.g. case management, employment training, substance use disorder treatment) in line with 24 CFR 578.75(h)?
	100.00%

1C-4. Consulting with ESG Recipients.

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

(limit 2,500 characters)

A. The CoC consults with ESG entitlement jurisdictions through the CoC's governance structure outlined in the CoC Charter. The Charter identifies five ESG entitlement jurisdictions within the CoC's geography, including Maricopa County, the City of Phoenix, the City of Mesa, the City of Tempe, and the City of Glendale, and requires coordinated planning and service delivery among these funders. ESG entitlement jurisdictions hold fixed seats on the Funders Committee, which is a Standing Committee of the CoC Board. Through this committee, ESG recipients participate in coordinated funding discussions, alignment of investments, tracking of system resources, and identification of gaps that need CoC Board attention. ESG recipients also work with other funders to align reporting and procurement standards, so requirements remain consistent across programs.

ESG recipients also hold designated seats across other Standing Committees. On the Coordinated Entry Committee, ESG representatives support referral protocols, access monitoring, shelter capacity review, and system flow analysis. On the Compliance and Performance Monitoring Committee, ESG recipients participate in performance reviews, tool development, and feedback on written standards. On the HMIS and Data Systems Coordination Committee, ESG recipients support data collection expectations, shelter onboarding, and review of dashboards that track referrals, placements, and returns. These seats ensure shared decision-making across committee domains.

The CoC and ESG recipients jointly plan and complete the annual Point-in-Time and Housing Inventory Counts. ESG partners participate in methodology development, volunteer training, and validation of count data. After the count, ESG jurisdictions join debriefs and use findings to guide ESG allocations and target resources for shelter, outreach, and housing. The CoC provides PIT, HIC, and system performance data to Consolidated Plan jurisdictions and consults with ESG recipients on metrics and language used in local planning documents. Finally, CoC and ESG providers collaborate on key policy initiatives, such as the Statewide Gender-Based Violence and VAWA Emergency Transfer Plan, to meet federal requirements and support alignment across programs.

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 with shelter providers through a region-wide Coordinated Entry (CE) system. This system includes access points for single adults and multiple family access sites, with mobile access embedded in street outreach. Shelter intake teams use the CE workflow to complete standardized assessments and refer households to housing navigation and services.

Shelter providers participate in weekly case conferencing tailored by subpopulation, where By-Name Lists and HUD-aligned prioritization are used to match available housing units and resources. Warm hand-offs from shelter to housing case managers are scheduled and tracked, supporting faster placement; recent CE reporting shows efficient movement from referral to move-in under the case-conferencing model. Referrals are documented in HMIS. The CoC and HMIS Lead have onboarded additional shelters and improved sheltered PIT Count data quality, ensuring shelter partners can generate timely referrals and monitor outcomes. In addition, the CoC coordinates with the Arizona Shelter Network (ASN), established in 2026. ASN shares best practices and coordinates services among four of Arizona's largest shelters in order to reduce shelter turn aways, increase shelter utilization, decrease length of stay, and increase positive exits from shelter.

CE lead agencies provide onboarding and quarterly training for shelter staff on assessment, prioritization, referral and documentation, with additional modules on safety planning and confidentiality for survivors and comparable-database workflows for victim service providers. Policies and procedures are updated through CoC Committee vetting and posted publicly; shelters receive clear guidance on how to escalate urgent needs (e.g., crisis and DV pathways) without interruption to service.

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 with state and local governments in accordance with its HMIS Privacy and Security policies and HUD standards. The HMIS Lead supports compliant collection, storage, and disclosure, and victim service providers use HUD-compliant comparable databases, so survivor information remains confidential while aggregate trends inform planning.

The CoC submits and disseminates aggregate results of all required HUD data products – including the PIT, HIC, SPMs, HDX competition reports, and LSA files – to help jurisdictions assess system gaps and performance. Beyond annual counts, the CoC regularly shares HMIS and System Performance data in aggregate, meeting data privacy requirements. The CoC uses aggregate data for monthly homelessness trend reports, which are published on the CoC's website and disseminated to stakeholders. The CoC also supports several tools dependent on data, including the GIS-based Homeless Outreach Viewer, which uses HMIS information to track outreach encounters and encampment locations.

Data sharing is further supported through committee structures where policy, procedure, and data release requests are reviewed. The HMIS and Data Systems Coordinating Committee (HDSCC) is responsible for reviewing the HMIS Data Security and Privacy Plan on an annual basis, as well as reviewing data requests from outside partners, researchers, and community stakeholders. ESG recipients and local government partners hold designated seats on key committees (Coordinated Entry Committee, Compliance and Performance Monitoring Committee, HDSCC) and CoC Board, where the HMIS Lead presents aggregate dashboards and System Performance Measures. These partners review trends, discuss CE flow results such as referrals, placements, and returns, and identify follow-up actions to improve shelter-to-housing pathways and encampment responses.

The CoC contributes to the statewide data sharing through the Data Warehouse for Enterprise Linkages (DWEL-AZ), which connects Arizona's three CoCs, Arizona's Medicaid agency, research partners, and other state entities. At the local level, the CoC maintains a data-sharing agreement with the Department of Veterans Affairs to support coordination for Veteran Service Organizations.

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 uses non-HMIS data sources alongside HMIS to improve care coordination and resource targeting while following its HMIS Privacy Notice and HUD standards. Working with the HMIS Lead, the CoC conducts a monthly data match with Arizona Medicaid, so managed care plans can identify members experiencing homelessness and coordinate covered services including case management, behavioral health care, transportation, and follow-up that support housing stability. The CoC also maintains active data-sharing agreements with the U.S. Department of Veterans Affairs (VA) to support joint case reviews, care coordination, and warm referrals through HUD-VASH, SSVF, and the Phoenix VA Community Resource and Referral Center. This supports client-level information-sharing that improves care engagement for veterans and other high-need participants. At the state level, the CoC supports data sharing through the Data Warehouse for Enterprise Linkages (DWEL-AZ), which connects data from Arizona's three CoCs, the state Medicaid agency, research partners, and other state entities. Public health data is incorporated into operational decisions, including Maricopa County's transient-death and heat-fatality reports that guide outreach deployment and heat-relief activation. HMIS engagement data is integrated into a password-protected, secure GIS Outreach Viewer to help outreach teams prioritize follow-ups in areas identified through public health and field operations.

To strengthen diversion and prevention, the CoC reviews data from statewide referral systems, including Arizona 2-1-1 and eviction-prevention hotlines, and compares call trends with HMIS inflow data. Admission, discharge, and transfer information shared by partners support coordinated scheduling of housing navigation, treatment appointments, and supportive services prior to release. Victim service providers use HUD-compliant comparable databases to ensure survivor safety while contributing aggregate information for planning. Through designated seats on the HMIS & Data Systems Coordinating Committee and CoC Board, government partners and ESG recipients review de-identified dashboards and trend analyses and collaborate with the CoC to set priorities grounded in information extracted from combined HMIS and external datasets.

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 the Maricopa County Workforce Development Division (Local Workforce Development Board/WIOA Title I-B) to connect participants to American Job Center services, training, and job placement support. The CoC also coordinates with City of Phoenix and Arizona Department of Economic Security (Arizona@Work) workforce programs to expand access to employment services. In addition, CoC providers work with Dress for Success and Fresh Start to prepare individuals for employment.

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 providers operate in co-response with first responders, mental health crisis-response teams, community paramedicine teams, and law enforcement to coordinate warm hand-offs for crisis care, Coordinated Entry (CE), and housing navigation. Outreach teams access real-time locations and last-known contacts through a password-protected and secure ArcGIS-based Outreach Viewer and align deployments with police, fire, and public works during hotspot operations. Weekly case conferencing then matches referred individuals to available housing and services, reducing missed connections after engagement.

To encourage positive interactions during encampment outreach, the CoC conducts joint briefings with law enforcement and municipal partners and offers referral scripts and contact protocols so officers can initiate direct links to CE access points and crisis providers in the field; jurisdictional partners receive aggregate HMIS/PIT/HIC trend briefings to target joint operations where they are most effective.

When court involvement occurs, outreach teams work with the City of Phoenix Public Defender's Office and Community Court to translate citations into service-linked plans. Keys to Change (CE Lead Agency) hosts monthly Homeless Court at Key Campus, with on-site advocates coordinating same-day warm hand-offs to CoC providers. Finally, the CoC partners with judicial and public safety leaders to develop strategies and review outcomes through CoC governance structures.

Finally, the CoC supports cross-system coordination by hosting regular crisis response and law enforcement roundtables to bridge gaps in services, refine referral pathways, and identify opportunities for coordination.

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)

The CoC incorporates family and support network reunification into its diversion and housing strategies to reduce homelessness entries and support positive exits. In 2024, the CoC released a regionwide Prevention and Diversion Toolkit for cities, towns, and tribal communities to strengthen coordination with other systems of care and guide the development of diversion programs. The Toolkit helps case managers understand when reunification can be effective and safe, with steps for communication, safety checks, and integrating reunification into housing plans. Four CoC trainings in the CoC's learning management platform instruct providers on applying diversion within shelter settings, identifying viable support networks, and conducting reunification assessments. CoC funded and ESG funded providers dedicate resources to help households reconnect with safe support networks, including travel arrangements, transportation costs, and coordination with service providers in other locations when reunification outside Maricopa County (MC) is appropriate.

Providers use CE assessments and diversion to identify reunification opportunities early in the shelter workflow. When reunification is appropriate, staff arrange travel, coordinate supports in the receiving community and follow up to confirm safe reconnection. The CoC incorporates reunification into case conferencing to allow navigators, outreach teams, and shelter staff to identify cases that could be resolved through a family or support network connection. Coordination with behavioral health providers strengthens reunification efforts by ensuring access to outpatient treatment, medication support, or crisis services in the receiving community.

Keys to Change, a Coordinated Entry (CE) lead agency, operates eviction diversion, diversion assistance, and flex funding programs to support household reunification and eviction prevention, helping over 1,199 individuals in FY26. UMOM, the CE lead agency for families, works with philanthropic partners to offer diversion and rapid resolution strategies designed to prevent family homelessness. In 2026, MC launched an eviction prevention program focused on the highest-eviction zip codes and is piloting an initiative with Justice Courts in collaboration with the National Center for State Courts's Housing Stability Work Group.

The CoC's Move On strategy identifies and assists participants ready to transition from CoC funded housing and reunite safely with family members.

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 CoC cooperates with local public safety agencies and does not impede lawful efforts to clear tents, reduce public drug use, apply danger to self or others processes, and share information in accordance with SORNA. The CoC's Coordination and Non-Interference with Local Efforts to Advance Protecting Public Safety Policy directs all CoC partners to support these activities while maintaining access to services. The CoC Board includes a designated law enforcement seat to ensure consistent communication with public safety departments.

Cities, towns, and Maricopa County (MC) coordinate encampment efforts with outreach teams, parks departments, and crisis units. Mobile Coordinated Entry access points focus on encampments, and outreach staff work alongside first responders to connect people immediately to shelter, assessment, diversion, transportation, and treatment. The City of Phoenix's PHX C.A.R.E.S. team and MC Hand in Hand outreach teams share information with CoC providers to support safe encampment closure and rapid linkage to services. The CoC hosts an annual roundtable with law enforcement and crisis response agencies to identify coordination needs and improve cross-system communication.

The CoC supports local efforts to reduce public drug use by working with behavioral health and crisis response programs. Outreach and housing providers coordinate with first responders when substance use or psychiatric concerns occur in public spaces. The CoC works with programs such as the City of Tempe's CARE 7 team and similar crisis response teams in Mesa and Chandler to pair behavioral health specialists with law enforcement personnel. Providers support petitions and procedures under state standards for danger to self or others, including involuntary commitment, and do not impede determinations made by authorized professionals.

Information sharing follows federal, state, local privacy laws, HMIS privacy and security policies. The CoC does not restrict lawful information sharing under SORNA.

The CoC assists first responders through shared maps, direct communication, and coordinated outreach coverage. The GIS-based Outreach Viewer helps identify locations needing outreach engagement and supports coordination during crisis calls and encampment operations. Outreach teams meet first responders at field sites and connect individuals to shelter, medical care, crisis stabilization, and assessment, ensuring synchronized public safety and service access.

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)

Local laws influence how quickly tents and encampments can be cleared. Twenty-five of the 28 jurisdictions in the CoC, covering over 99% of its geography, enforce public camping bans.

Recent litigation impacts encampment resolution efforts. An example is the 2023 court order requiring the City of Phoenix to close the largest downtown encampment, resulting in 82% of 716 unsheltered individuals accepting shelter before the court-ordered deadline.

The City of Tempe's urban camping ordinance, updated in 2018, requires structured response through CARE 7 and HOPE teams to use an encampment reporting dashboard for rapid identification.

In 2026, the City of Phoenix adopted Parks Ordinance G7514, which restricts unpermitted medical treatment, food distribution, and limits park permits, creating challenges for providers that rely on park-based outreach.

Eight cities and towns operate service first practices that support rapid clearance through Maricopa County's Hand in Hand outreach program. The Cities of Goodyear and Tolleson rely on their police departments for referrals to Hand in Hand. The communities of Avondale, Gilbert, Mesa, and Tempe operate local outreach teams, and the Town of Gilbert partners with the nonprofit AZCEND to offer services. The Cities of Glendale and Peoria divert nonviolent repeat offenders into services through their misdemeanor repeat offender programs.

To support these efforts, the CoC coordinates clearances with the City of Phoenix's Office of Homeless Solutions and PHX C.A.R.E.S. for outreach, assessment, and referral. During the court-ordered cleanup, outreach providers used tools maintained by the CoC, including the GIS-based Homeless Outreach Viewer, to track locations and coordinate coverage.

For restrictive policies, the CoC will work with providers to secure required permits when possible, or to move outreach to compliant locations such as mobile units, shelters, navigation centers, and Community Action Program (CAP) teams. CAP maintains six Crisis Response Units and six Behavioral Health Units with nearly 24-hour coverage, supporting encampment-related service needs.

Quantitatively, the CoC monitors referral to contact times and shelter placement rates during encampment operations with the goal of meeting the prior 82% percent engagement benchmark achieved under the Phoenix court order. The CoC will continue to host law enforcement and crisis response roundtables to enhance communication.

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)

Camping on public property is not allowed within the CoC's geographic area. Local governments enforce public-space regulations and coordinated response systems track encampment activity throughout the region. The annual PIT Count and follow-up fieldwork indicate a 12-14% decrease in unsheltered homelessness over the past year, reflecting the impact of local enforcement paired with expanded service access.

Court directives have also shaped current conditions. In 2023, a Maricopa County ruling required the City of Phoenix to close a large downtown encampment. The City of Phoenix reported that 82% of 716 unsheltered individuals accepted shelter ahead of the deadline, demonstrating measurable progress in clearing a large encampment while increasing service engagement. After this action, the City of Phoenix posted clear signage and continued daily encampment resolution tactics, resulting in fewer tents in the area.

Cities and towns across the region maintain ordinances that support coordinated abatement. The City of Tempe's urban camping ordinance prohibits tent-based dwelling on public spaces and relies on structured reporting tools and outreach teams to respond rapidly to encampment activity. The City of Phoenix uses its PHX C.A.R.E.S. system to log encampment reports, connect individuals with services, and coordinate multidepartment cleanup operations. The City of Peoria uses interdepartmental teams to clear encampments and connect people with housing. These strategies allow the CoC to monitor encampment locations and track outcomes through shared mapping tools, including the GIS-based Homeless Outreach Viewer, which displays HMIS outreach location data across Maricopa County.

In addition, the region invests heavily in strategies to reduce outdoor camping. The City of Phoenix and other communities have expanded shelter capacity, including 1,200 additional beds across various providers, to increase options for individuals who previously stayed outdoors. Behavioral health partners are also increasing transitional placements, including new beds on the Arizona State Hospital campus, contracted through Arizona's Medicaid agency.

Qualitatively, encampments today tend to be smaller, more dispersed, and resolved quickly through coordinated response and service connection. Local governments partner with the CoC through public safety roundtables and structured outreach operations, ensuring consistent communication when encampments appear.

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)

Local laws and policies influence how quickly the CoC and its partners respond to public illicit drug use. Thirteen of the 28 cities and towns in the CoC's region have active ordinances that ban public use of illicit substances. The City of Phoenix's 2026 Parks Ordinance G7467 prohibits unpermitted medical care and serving food in parks, which limits park-based outreach for programs serving individuals using illicit drugs. The City of Tempe's municipal code bans public marijuana use across all city-owned property, creating additional enforcement pathways when substance use occurs in public spaces. At the state level, Arizona's Good Samaritan Law encourages emergency calls during overdoses by protecting callers and the individual from arrest for possession, allowing outreach teams and first responders to direct individuals to immediate care.

Data from the 2023 Maricopa Department of Public Health assessment shows that 89.7% of people using illicit substances have past or current experiences of homelessness, and 60.8% meet the definition of chronic homelessness. Despite interest, 76.8% reported inability to access stable housing. In consideration, the CoC partners with Community Bridges, Inc. (CBI), which operates Project for Assistance in Transition from Homelessness (PATH)-funded behavioral-health programs, including 24/7 Access Point and Transition Point centers where law enforcement can bring individuals for assessment, brief intervention, or stabilization. These locations, which serve hundreds annually, give first responders safe options for immediate drop-offs and reduce time spent on repeat calls in public spaces. Police and outreach teams report faster connection to care and fewer repeat public-use encounters when drop-off locations are available.

To overcome restrictive policies, the CoC supports providers in securing required permits for structured outreach in parks or to shift activities to compliant locations such as mobile units, drop-in centers, or crisis response facilities. The CoC also hosts and participates in public safety roundtables with municipal partners and law enforcement to align communication and address gaps in referral pathways. Collaboration with researchers from local universities and HUD technical assistance efforts help evaluate local practices and develop strategies that balance enforcement with increased service access.

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)

Thirteen of the 28 cities and towns in the region have active ordinances that ban public use of illicit substances. The Maricopa County Public Health Department tracks overdose trends through a public dashboard, which shows that fatal overdose rates were stable from 2021 through 2024, then rose by 16 percent in 2025 with opioids as the primary driver. Methamphetamine use remains the most common non opioid substance involved in overdose deaths, and cocaine related fatalities also increased in 2025. From 2021 to 2025, males consistently accounted for approximately three-quarters of fatal overdoses. Most fatalities occur among individuals ages 25 to 64, with the highest concentration in the 25 to 44 age range. Fatalities among those aged 25 to 34 increased nearly 30 percent from 2024 to 2025. As of September 17, 2026, Maricopa County's opioid fatality rate is 13.3 per 100,000, compared to the statewide rate of 12.7. Maricopa County reports a non-fatal opioid overdose rate of 44.4 per 100,000, compared to the statewide rate of 36.9. The Centers for Disease Control and Prevention report 53.9 suspected nonfatal overdoses per 10,000 total emergency department (ED) visits across the 47 participating jurisdictions, whereas Arizona's rate of nonfatal overdoses per 10,000 ED visits is 66.3. Community-level impacts associated with overdoses include 16,338 emergency and inpatient hospital visits and 7,082 emergency medical services and law enforcement responses in 2026. Individuals most represented in these incidents are predominantly male, white, and between the ages of 25 and 44. These trends help inform coordination between public health partners, behavioral health agencies, crisis response teams, and CoC providers as jurisdictions implement policies to reduce public drug use, expand treatment access, and strengthen outreach in areas with high overdose activity.

The City of Phoenix reports on suspected opioid overdoses by location. While 2,000 suspected opioid overdoses occur in residential settings, 3,900 are in public spaces ranging from transportation and roadways to urban environments. The downtown Phoenix encampment, previously associated with public illicit drug use, is now monitored five days a week by street outreach teams to support its safety and continued resolution.

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)

Arizona law (Title 36 of the Arizona Revised Statutes) provides clear standards for intervening when a person is a danger to self or others. Courts may initiate court-ordered evaluation (COE) and court-ordered treatment (COT) when the criteria for danger to self, danger to others, persistent disability, or grave disability are met. These laws allow behavioral-health partners to initiate evaluation or treatment without procedural barriers, supporting emergency care, evaluation holds, and assisted outpatient treatment. The Cicero Institute cites the Treatment Advocacy Center as scoring Arizona a "B" in providing involuntary treatment for psychiatric illness.

The CoC and its providers work with the behavioral health (BH) system to ensure COE/COT are implemented to best serve individuals experiencing homelessness with acute BH needs. Outreach teams, including PATH providers, use BH specialists to identify behaviors meeting COE/COT thresholds and assist with pre-petition screening. Law enforcement and mobile crisis teams transport individuals to Community Bridges, Inc. (CBI) Access and Transition Point facilities for clinical evaluation for 24-hour triage, assessment, and stabilization. CBI reports hundreds of crisis drop-offs annually, and first responders report fewer repeated crisis calls after COE/COT or short-term stabilization.

CoC systems also coordinate with the Maricopa County Mental Health Court, which manages COE/COT evaluations and treatment orders at Valleywise Behavioral Health Centers and the Arizona State Hospital. Specialty courts provide structured settings where individuals experiencing homelessness and behavioral health crises can receive treatment and resolve legal barriers. The City of Phoenix Community Court supports individuals whose needs span legal, homelessness and behavioral health systems. Since early 2024, the Court has enrolled 804 participants, with 411 being connected to shelter or housing, 195 linked to mental health or substance use treatment, and 214 graduating the program.

The CoC uses Board-approved written standards to support speed and consistency in the referral process. To mitigate the negative impacts of COE/COT, the CoC will maintain warm hand-offs by pre-scheduling CE assessments, communicating with courts and crisis providers, and rapidly re-engaging individuals in housing pathways.

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)

Arizona Revised Statute (ARS) §13-3821 requires maintenance and reporting to the statewide sex offender registry through the Department of Public Safety (DPS). While the Arizona registry is not fully SORNA compliant, it partially-complies by updating the National Crime Information Center registry within required federal timeframes and issuing required public notifications.

The CoC follows all applicable sex offender laws to ensure safety within its programs, especially those serving families and vulnerable populations. All family and domestic violence programs prohibit sex offenders and conduct background screening using the DPS registry. Single adult programs are not required to serve sex offenders, and it is at the programs or its funding source's discretion to do so.

All CoC direct service providers must comply with ARS §41-1758.03, which requires staff to have a background check for sex offenses and other criminal offenses to secure a fingerprint Clearance Card required to work with children or vulnerable populations. This requirement is part of program compliance audits.

CoC providers responded to 150 law enforcement verification requests in 2025, with 98% completed within 24 hours. Providers report that sex offender registry access reduces programmatic barriers by allowing providers to proactively identify program options that do not violate state laws on where registered sex offenders may reside. Where Arizona SORNA compliance deficiency limits notification between jurisdictions or other legal systems' sex offender status, the CoC coordinates directly with local law enforcement during outreach.

The CoC provides staff with training on legal requirements and best practices for information sharing and cooperates with law enforcement in addressing sex offenders and public safety. CoC HMIS policies define requirements for sharing HMIS and program data with law enforcement for public safety purposes.

The CoC will continue to strengthen collaboration and communication with law enforcement to confirm registry data during housing placement, safety checks, and case planning and to overcome restrictive gaps created by partial SORNA implementation. Through program compliance monitoring, the CoC will ensure programs leverage and comply with required sex offender-related legal requirements for public safety. The CoC will also amend its policies as necessary to comply with any further changes to state or federal law related to sex offender status.

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 uses a coordinated, regionwide outreach strategy to reach individuals and families experiencing homelessness, including people who are not otherwise engaged in services. Outreach coverage spans the full geographic area and includes more than 60 outreach teams (PATH-funded teams, 1115 Medicaid waiver-supported teams, and jurisdiction-operated units) with staggered morning, evening, and weekend schedules. Teams work consistently in fixed locations to build familiarity, maintain repeated contact, and reach people living outdoors during high-heat months or in remote, high-risk areas. Most outreach teams also incorporate peers or behavioral health specialists to better engage and connect unengaged special populations to appropriate services including crisis, behavioral health and SUD services.

The CoC's jurisdictions operate additional outreach teams to cover and engage populations. The jurisdictions of Phoenix, Chandler, Avondale, Gilbert, Mesa, and Tempe operate outreach programs. Twenty-nine smaller communities receive outreach support through Maricopa County's Hand in Hand program. Outreach teams also coordinate with local first responders. Jurisdictions divert nonviolent repeat offenders to specialty courts and services through the Maricopa Repeat Offender Program, to reduce law enforcement encounters and improve behavioral healthcare access.

To support regional coordination, the CoC hosts a GIS Outreach Viewer using de-identified HMIS data to display last-known contacts and encampments. This tool helps identify gaps, coordinate coverage, and ensure full geographic reach. The CoC also partners with the statewide 211 program operated by Solari so individuals seeking help by phone or text can be screened for homelessness and referred to local outreach or Coordinated Entry (CE) access points. Many outreach teams also function as mobile CE access points to enable rapid referrals to housing opportunities.

Once contact is established, outreach teams complete CE assessments, schedule appointments with housing navigators, and participate in weekly case conferencing to support rapid connections to shelter or housing. To strengthen outreach quality and consistency, the CoC collaborates with state partners, including state human-services agencies, PATH administrators, and Medicaid waiver leads, to develop statewide Standard Operating Procedures (SOPs) that align expectations across programs and funding streams.

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.	Child Literacy and Absenteeism Programs	Yes

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)	Yes
5.	Technical College(s)	Yes
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 CoC Written Standards, published on the public CoC website, require all CoC-funded projects serving families with children or unaccompanied youth to inform them of their educational rights. Programs must designate staff responsible for school enrollment, connection to community educational supports, and ensuring full protections of the McKinney Vento Act. The Written Standards require projects to document the sharing of written materials provided at intake explaining enrollment rights, transportation protections, and access to school-based services, and to link families and youth to local McKinney Vento Liaisons.

The Coordinated Entry (CE) Policies, also published on the CoC's website, specify that projects must inform families and unaccompanied youth of their educational rights during the intake process, provide written materials, and ensure connection to McKinney-Vento Liaisons, including help with school enrollment when needed. CE Policies also direct programs to consider children's educational needs when making housing referrals, including placing families as close as possible to a child's school of origin. The Family Housing Hub CE Manual reinforces family-friendly practices and emphasizes client choice related to school location and scheduling needs.

To ensure implementation, the CoC monitoring process includes review of McKinney-Vento compliance. Providers are evaluated on adherence to Written Standards and CE Policies, including documentation of education rights notification. In FY26, these requirements were strengthened through the addition of new oversight activities in the CoC's policies. The Youth Action Board (YAB), Collaborative Applicant staff, and the DWEL team are exploring linking McKinney-Vento information systems with DWEL.

The CoC's Learning Management System (LMS) provides required annual staff training on McKinney-Vento to ensure staff understand how to communicate education rights to families and youth.

The CoC embeds education-system and family-serving expertise within its governance structure. The Arizona Department of Education, multiple LEA McKinney-Vento liaisons, and family-serving providers, such as First Things First, Homeless Youth Connection, UMOM, Save the Family, A New Leaf, and Catholic Charities, maintain membership on CoC committees and workgroups.

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)

The CoC coordinates with foster care and child welfare partners to assist youth who are transitioning from public systems of care. Providers follow requirements in the CoC Written Standards, which state that programs serving families with children or unaccompanied youth must designate a staff person responsible for helping youth connect to community services and ensuring coordination during their transition. These standards guide coordination with foster care and child welfare staff so that youth entering CoC programs receive assistance aligned with their prior system involvement.

The CoC maintains ongoing collaboration with the Arizona Department of Child Safety (DCS) and contracted youth agencies. DCS staff participate in CoC committees and workgroups. Coordinated Entry access points meet with foster care/child welfare partners to support warm referrals for youth who are exiting foster care or extended foster care placements. Case managers coordinate with DCS workers to review safety needs, verify documentation, and ensure access to behavioral health, education, employment, and housing supports. When DCS identifies a youth at risk of homelessness, program staff notify CE access points so the youth can be assessed quickly and connected to appropriate housing pathways. Public Housing Agencies (PHA) across Maricopa County coordinate with DCS and CE access points to verify eligibility, accelerate referrals, and support data integration into regional planning. PHAs also maintain MOUs with the CoC to streamline Family Unification Program vouchers. Additionally, the CoC collaborates with DCS and PHAs to increase statewide program participation in the Melania Trump Foster Youth to Independence Initiative (FYI).

The CoC's Lived Experience Committee and Youth Action Board strengthen this coordination by elevating lived expertise with child welfare and foster care systems into system design. Implementation of these coordination requirements is monitored through the CoC's annual monitoring process, which reviews provider documentation in HMIS, adherence to Written Standards, and evidence of communication with child-welfare partners.

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 CoC coordinates with providers that receive federal support for serving runaway and homeless youth (RHY-funded). Within the CoC, RHY providers such as Lifeology (Basic Center Program) and Homeless Youth Connection (Transitional Living Program) participate in ongoing planning and referral processes through the Youth Homeless Systems Improvements (YHSI) grant, which includes collaboration with programs that operate street outreach, crisis response, transitional housing, and maternity and parenting youth services. These providers meet monthly with CoC staff to review referral steps, share updates on available services, and support warm handoffs from outreach, schools, law enforcement, and Coordinated Entry (CE) access points. RHY providers also participate in youth outreach surveys, strengthening regional data collection and engagement.

Youth providers work with the CoC to identify youth who are disconnected from family supports or who are leaving unsafe situations. Staff coordinate with provider case managers to ensure youth receive immediate placement in safe locations, along with case management support that includes access to health care, school enrollment assistance, and connection to behavioral health services. When youth providers identify a young person at risk of homelessness, they notify CE access points for rapid assessment and placement into the youth housing pathway.

Through the YHSI grant, the CoC collaborates with RHY-funded providers to strengthen shared procedures, improve diversion techniques for youth who can reconnect with safe support networks, and address gaps in crisis response and longer-term housing. Providers coordinate with the Arizona Department of Child Safety when a youth has an open case or is leaving a placement, and work with the CoC to maintain consistent access to case conferencing. Youth providers share de-identified information needed for planning and align their referral processes with CE to ensure that youth are engaged and connected to housing through established pathways.

The CoC also collaborates at least quarterly with regional youth partners including Homeless Youth Connection, Keys to Change, and Arizona Youth Partnership to expand referral options and stabilize youth. Additionally, AZCEND's Community Action Program (CAP) supports RHY-eligible youth and families by providing education and employment referrals, financial education, eviction prevention, and housing access.

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 includes multiple RRH and TH projects that primarily or exclusively serve families with children per 24 CFR 578.93(b). According to their last APR, 98.67% of households served by UMOM's Next Step Housing 3 Consolidated RRH project were families with children. Save the Family's RRH and TH, A New Leaf's DV RRH, UMOM's Next Step Housing TH, and Rooted in Grace's Health + Housing TH also primarily or exclusively serve 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)

Projects identified in 1C-13 provide comprehensive supportive services designed to increase earned income and strengthen long-term financial stability so participants can maintain housing and pay rent.

UMOM's RRH project Next Step Housing 3 Consolidated provides weekly case management, structured workforce development, employment training, childcare supports, benefits assistance, and wraparound services. UMOM reports that 59% of households maintained or increased total income, exceeding HUD's 50% benchmark.

Rooted in Grace Foundation's Health + Housing TH project delivers a structured workforce pathway offering Community Health Worker and peer support certification; Barbell Saves Project food service certification; and Dress for Success employment preparation, priority childcare access, and onsite benefits enrollment.

Save the Family's RRH and TH projects provide coordinated employment and career development services, workforce training, financial capability coaching, and linkages to Arizona@Work (Arizona's Workforce Connections), MesaCAN, and other employment partners. Families develop individualized Housing Stability Plans that include job readiness, budgeting, employment advancement, childcare, transportation supports, and access to mainstream benefits.

A New Leaf's DV RRH project offers employment assistance, financial coaching, transportation, benefits enrollment, and connections to Arizona@Work and internal programs such as Financial Empowerment Services. Case managers help participants create Housing Stability Plans with goals tied to employment, wage growth, and long-term stability.

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)

Projects identified in 1C-13 leverage funding from mainstream family service systems to increase household stability and support income growth.

UMOM's RRH project Next Step Housing 3 Consolidated helps families secure mainstream benefits such as Temporary Assistance for Needy Families (TANF), SSI/SSDI, nutrition assistance, Medicaid enrollment, and childcare subsidies. UMOM's structured case management model includes benefits assessments and connections to Arizona Department of Economic Security (DES) and other agencies to reduce financial barriers and support income growth.

A New Leaf's DV RRH project helps participants obtain TANF, nutrition assistance, Medicaid enrollment, childcare subsidy programs, and other DES supports. Case managers provide direct benefits navigation and connect participants to internal Financial Empowerment Services that specialize in maximizing income through mainstream benefits. Housing Stability Plans include identifying which benefits families qualify for and assisting with applications to stabilize income during the rental period.

Rooted in Grace Foundation's Health + Housing TH project integrates benefits enrollment into its service model, helping participants secure TANF, SSI/SSDI, nutrition assistance, DES childcare subsidies, and other mainstream supports. For pregnant, postpartum, or disabled survivors, income development includes helping participants access SSI/SSDI or TANF when appropriate, ensuring families can meet basic needs while pursuing workforce pathways.

Save the Family's RRH and TH projects coordinate extensively with Arizona's mainstream benefit systems. Case managers assist families in securing TANF, SNAP, childcare subsidies, Medicaid enrollment, and transportation support while they work toward employment goals. Their financial capability coaching includes benefits screening, and partnerships with Arizona@Work, MesaCAN, and other agencies to support access to subsidized training funded through state and federal systems.

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)

Projects identified in 1C-13 combine housing assistance with childcare, parenting support, pregnancy-related and child healthcare, and education to promote family stability and long-term success.

UMOM's RRH project, Next Step Housing 3 Consolidated, combines housing with childcare, healthcare referrals, parenting support, family case management, education services, and behavioral health connections. Families receive structured wraparound supports such as childcare assistance, school enrollment help, and referrals for maternal and child healthcare.

A New Leaf's DV RRH project combines rental assistance with child and family supports such as childcare navigation, safety planning for parenting survivors, referrals to healthcare and behavioral health providers, educational supports for children, and family case management. Parents receive help enrolling children in school, accessing childcare subsidies, and connecting to pediatric and maternal healthcare.

Rooted in Grace Foundation's Health + Housing TH project integrates housing navigation with priority DES childcare access, parenting supports, domestic violence safety planning, and pregnancy-related care coordination for pregnant or postpartum survivors. Through its trauma-informed assessment and individualized Health + Housing Care Plans, participants receive connections to prenatal care, pediatric health services, and developmental supports for children.

Save the Family's RRH and TH projects blend housing stabilization with comprehensive family-centered services. Families receive childcare, transportation, parenting education, trauma-informed counseling, and developmental and educational supports for children. Save the Family partners with local healthcare providers such as Neighborhood Outreach Access to Health (NOAH) and Adelante Healthcare to ensure access to child and maternal healthcare, and offers enrichment, school readiness, and social-emotional programming for children.

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 partners with the Phoenix VA Community Resource and Referral Center to conduct veteran outreach, provide Coordinated Entry access for veterans, and refer veterans, servicemembers, and families to services from organizations operating SSVF, GPD, HVRP, and other veteran-focused grant programs. Seven Veteran Serving Organizations currently participate in CoC governance, regional planning, and coordination. The CoC also partners with the VA to share data to VA repositories.

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)

The CoC partners with the Arizona Coalition to End Sexual and Domestic Violence and victim service providers (VSPs), such as Sojourner Center, A New Leaf, and Chrysalis, to coordinate confidential referrals, safety planning, and survivor-specific protocols. The CoC operates a separate Coordinated Entry process for survivors that is fully compliant with VAWA 2022 requirements and best practice standards. The CoC also maintains a designated VSP seat on the CoC Board.

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 partners with community and specialty courts and re-entry providers such as Axiom Care, Maricopa County, and Community Bridges, Inc., to coordinate release planning and connect people exiting incarceration with housing, shelter, and services. The state Medicaid system has an ex officio seat on the CoC Board and strengthens release planning and coordination through the 1115 waiver. The CoC is establishing HMIS data sharing with justice system partners through regional data initiatives.

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

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

(limit 500 characters)

The CoC partners with Circle the City, a Federally Qualified Health Center (FQHC), to provide medical respite, street medicine, case conferencing, warm hand-offs to housing, and outpatient care for individuals with high medical needs. The CoC also collaborates with the state Medicaid system and contracted health plans to fund supportive services and coordinate care, leveraging Medicaid resources and the 1115 waiver for re-entry and to sustain stability post-placement.

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

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

(limit 500 characters)

The CoC partners with Area Agency on Aging (Region One) and with CoC providers with dedicated senior sites like Central Arizona Shelter Service's Haven, the first emergency shelter in the region designed for adults 55 and older. In addition, the CoC maintains a memorandum of understanding with Justa Center, an organization serving older adults, to coordinate referrals to residential/assisted living and aging-specific supports.

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)

Native American Connections operates three PSH projects, Stepping Stones II, Stepping Stones III, and Camelback Pointe, that prioritize individuals experiencing chronic homelessness. In their most recent APRs, Camelback Pointe and Stepping Stones III served 100% chronically homeless individuals, and Stepping Stones II served 97.37%. These projects represent 127 units and \$3,168,034 in funding.

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)

Stepping Stones II, Stepping Stones III, and Camelback Pointe, operated by Native American Connections (NAC), provide on-site behavioral healthcare through an integrated service model. NAC's communities are staffed 24/7, ensuring immediate access to assistance, crisis response, and support for residents with complex behavioral health needs. Staff maintain regular contact with residents, allowing them to identify changes in wellbeing and intervene early when behavioral concerns, substance use, or other circumstances threaten housing stability.

Each resident is connected to a Case Manager who develops an individualized service plan and increases or decreases service intensity as needed. Case Managers coordinate behavioral health care, access to treatment and recovery services, transportation, benefits assistance, budgeting support, and connections to community resources. NAC's integrated healthcare system offers primary care, behavioral health services, psychiatric care, substance use treatment, and care coordination. The outpatient clinic and Mobile Health Initiative bring medical and behavioral healthcare directly into NAC housing communities, reducing barriers for residents with disabling conditions or long histories of homelessness.

NAC also partners with community providers, including Circle the City, Native Health, Terros Health, Mercy Care, Oak Street Health, Phoenix Indian Medical Center, the Department of Veterans Affairs, Wesley Med Van, Hospice Promise, Crossroads, Granite Mountain Recovery Center, and Vogue Recovery Center. These partnerships expand access to behavioral health services, medical care, recovery supports, hospice care, transportation, and specialized interventions. Residents benefit from onsite recovery groups, peer support, wellness and health education, nutrition workshops, creative arts activities, and life skills classes that encourage engagement, reduce isolation, and build pathways to further treatment and support.

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)

Stepping Stones II, Stepping Stones III, and Camelback Pointe, operated by Native American Connections (NAC), follow a structured policy and practice for assessing level of care needs for residents. NAC's 24/7 staffing model allows teams to identify changes in resident wellbeing early and determine when needs exceed the scope of onsite services. Case Managers (CM) conduct ongoing assessments, update individualized service plans, and increase service intensity when indicators suggest declining stability or emerging behavioral or medical concerns. This aligns with the CoC Written Standards requirement that PSH projects continuously assess supportive service needs and coordinate services to ensure long-term stability.

Regular home visits, scheduled check-ins, and monthly Talking Circles focused on recovery and wellness enabled staff to identify when residents may benefit from additional support. When higher-level care is needed, CMs work directly with NAC's residential treatment programs, including two treatment facilities near the PSH communities, and its Intensive Outpatient Services. Because housing and treatment programs operate within the same organization, NAC teams streamline referral, coordinate documentation, arrange transportation, and maintain communication throughout services. NAC staff support continuity of care by assisting residents through step-down levels of care in treatment and when returning to housing after stabilization or clinical discharge.

NAC partners with Granite Mountain Behavioral Healthcare, Terros Health, La Frontera, REN, and Community 43 for crisis response, assessments, outpatient and residential treatment, and specialized behavioral health services. These partnerships allow CMs to match residents with appropriate care based on individual needs, barriers, and treatment readiness. Program data show active utilization of treatment options, with 21% of residents accessing treatment during the reporting period, demonstrating consistent assessment and referral practices.

This coordinated approach reflects CoC policy requiring ongoing evaluation of supportive service needs and ensuring appropriate service coordination to maintain long-term stability. NAC's practice of assessing supportive services, monitoring risk, connecting residents to residential or outpatient treatment, and supporting post-treatment transitions demonstrate an effective policy for assessing and responding to needs for higher levels of care.

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)

Stepping Stones II, Stepping Stones III, and Camelback Pointe, operated by Native American Connections (NAC), use a structured policy and practice to assess resident readiness for unsubsidized or other permanent housing. NAC's model emphasizes ongoing housing stability evaluation, individualized goal progress, and needed supportive services levels, consistent with the CoC Written Standards requirements for continuous supportive service needs assessment and long-term stability coordination.

Upon entry, each resident engages in tailored housing stability planning through a written Service Participation Agreement. Case Managers maintain regular contact, conduct monthly home visits, and monitor financial stability, income, service engagement, lease compliance, and progress toward resident-defined goals. These touchpoints allow NAC staff to identify when residents progress toward independence and begin structured Move-On discussions.

The CoC provides projects with a Moving On Assessment, a tool to evaluate factors such as income, benefits access, behavioral health stability, daily living skills, and tenancy skills. The assessment supports staff in determining when residents can transition to unsubsidized housing or other permanent housing options without intensive supportive services. Project staff have access to a Move-On Strategy training course in the CoC's Learning Management System, which guides programs to reassess service needs, prepare residents for exit, and connect them to long-term supports when needed, to prevent returns to homelessness.

NAC's partnerships strengthen resident financial capability and transition readiness. Staff assist residents in securing or maintaining benefits (SNAP, SSI, SSDI, Medicaid, Medicare, Veterans benefits), and workforce supports from Phoenix Indian Center and vocational rehabilitation counselors help residents find employment and increase income. ESUSU, a financial technology credit-building platform, helps residents build credit, while Venture Residences provides tenant-rights education and connections to other permanent housing options.

When a resident is identified as transition ready, Case Managers help plan next steps, including community housing providers referrals, document needs, budgeting, benefits renewals, and case management linkage, if appropriate. This approach aligns with CoC guidance encouraging programs to ensure long-term client stability with further case management when needed.

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.	09/29/2026
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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.	09/29/2026
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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.	09/22/2026
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.	09/22/2026
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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 follows a structured, Board-approved reallocation process that evaluates all renewal projects through a threshold review and APR-based performance scoring related to successful exits, income attainment, length of time in the program, project occupancy and high-need population served measures. Additional scoring measures include HMIS data quality, Coordinated Entry participation, overall utilization rates, grant spenddown, and monitoring results. The Rank & Review Committee (RRC) uses objective scoring ranges, median-based system level performance thresholds, and system-need alignment to identify projects that may warrant reallocation. Projects with chronic underspending, scores at least 10% below the median, persistent monitoring issues, or misalignment with system needs may be recommended for reallocation. The CoC Board reviews RRC recommendations and approves final prioritization.

2. During the FY26 local competition, the RRC applied all elements of the above-mentioned process. All renewal projects met threshold requirements and aligned with system needs. No renewal project scored below the reallocation threshold or demonstrated conditions listed above such as significant underspending or unresolved monitoring findings that would qualify it as low performing or less needed. Two renewal projects requested to discontinue operations. No project presented performance-based risk factors that would justify reallocation.

3. The CoC did not reallocate any projects due to poor performance or lack of need. The reallocations occurring in FY26 reflect planned and voluntary Transition Grants, which convert existing PSH or RRH funded projects into new TH or SSO projects based on updated HUD and CoC Board priorities rather than performance deficiencies. The new transition grants were evaluated in accordance with the CoC Board established policy.

4. Performance- or need-based reallocation was not warranted for FY26 because no renewal projects met the criteria for low performance or reduced need, and because new project proposals did not exceed the performance of compliant renewal projects. However, a new transition project created through the voluntary reallocation of a renewal project did not meet HUD and CoC requirements and was not prioritized.

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)	WellSky
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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.	Single CoC
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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)

The CoC did not make any changes to PIT count methodology between 2025 and 2026. The CoC worked closely with its HMIS Lead to implement improved data quality procedures on both HMIS participating entities and non HMIS participating entities related to the Housing Inventory Count and PIT sheltered counts. These improved HIC and PIT data quality procedures ensured the CoC had an accurate inventory of ES, SH, TH, RRH, PSH, and OPH beds, which in turn strengthened the Rank and Review Committee's scoring process. Because the Rank and Review policy requires that funding decisions reflect current system needs and capacity, the updated HIC data-informed project prioritization, scoring, and tiering recommendations ensure resource allocation aligned with accurate system-wide housing availability.

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)

Based on January 2024 and January 2025 PIT Count data, the CoC counted an increase of 22 encampments and 155 people living in encampments. In response, the CoC and its jurisdictions enacted local and regional strategies to reduce encampments and connect individuals to services.

1) By the end of the reporting period, 89% of local jurisdictions in the CoC – covering almost 100% of the CoC’s urban geography – passed or enforced anti-camping ordinances. Local jurisdictions have expanded integrated law enforcement and service strategies. During the reporting period, Maricopa County’s Hand in Hand outreach program engaged 140 encampments, closed 35% of them. The City of Phoenix’s PHX C.A.R.E.S. encampment reporting hotline increased public awareness, resulting in 9,336 camp reports and the clearing of over 1,184 tons of material. In addition, the City of Phoenix, the CoC’s largest municipal shelter funder, implemented a model law enforcement coordination policy for its contracted shelters. The Cities of Tempe, Chandler and Mesa established integrated peer outreach workers, behavioral health staff, and law enforcement teams to expedite connections to shelter, treatment and supportive services. Arizona’s Medicaid agency implemented its 1115 Waiver program to allow Medicaid reimbursement for street outreach and wrap-around supportive services for individuals with serious mental illnesses.

2) Shelter beds were expanded at the regional level. By the end of 2025, CoC HIC data showed a 40% increase in emergency shelter beds and a doubling of transitional beds since 2022. During this time, the City of Phoenix opened the CoC’s first 200-bed sanctioned safe outdoor camping space with integrated services. The Safe Outdoor Space policies allow for coordinated drop-offs from first responders.

3) To assist outreach and engagement efforts, the CoC enhanced its GIS-based HMIS Outreach Dashboard Viewer, allowing outreach teams to track last known locations of encampments and observe trends over time. The Arizona Housing Analytics Collaborative (AzHAC), a three-university collaborative, began a partnership with the CoC to analyze and evaluate regional encampment data for improved response.

Together, these strategies have resulted in a 16% reduction in encampments and a 15% reduction in people living in encampments during the 2026 PIT Count.

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.	142
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.	997
2. Enter the reduction in the number of people in encampments during your evaluation period.	0

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

The CoC will continue to support, enhance and expand the strategies that have reduced encampments between the 2022 and 2026 PIT Counts by 9% and persons in encampments by over 20%. Between the 2025 and 2026 PIT count alone, these strategies reduced encampments by 16%.

Key regional active strategies include:

- 1) Supporting coordination between local law enforcement encampment abatement efforts, anti-camping enforcement, and provider outreach teams to engage, incentivize, and facilitate shelter and service access while improving communities;
- 2) Incorporating behavioral health, substance abuse, and service specialists and systems into local and regional outreach efforts to expedite access to treatment and services necessary to address homelessness root causes, such as the 1115 Medicaid waiver, which allows Arizona's Medicaid agency to fund shelter, housing, and services for persons with serious mental illness;
- 3) Working with jurisdictions to implement evidence-based practices within regional outreach efforts, including adoption of Standard Operating Processes and the City of Phoenix's policies for coordination with law enforcement, to increase provider service quality while improving coordination with law enforcement efforts;
- 4) Facilitating and supporting coordination between PATH, ESG, CoC, faith-based providers, and local government-funded outreach programs to maximize engagement of unsheltered individuals living in encampments;
- 5) Promoting and facilitating HMIS data sharing to improve coordination, identify target sites, and support evaluation of outreach efforts; and
- 6) Develop real-time coordination tools, such as the GIS-based Outreach Viewer that allows providers and jurisdictions to locate encampments, track outreach contacts, monitor service connections, and direct teams to areas with the highest need.

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)

Between 2024 and 2025, the CoC's first-time homeless SPM in ES/SH and TH decreased by 15% and 1,600+ individuals. While short of the 20% benchmark, this result reflects improvements in the CoC's impact on first-time homelessness. To further reduce first-time homelessness, the CoC will maintain and build upon the successful prevention and engagement strategies implemented over the past 2 years:

1) HMIS screening and assessments in the Coordinated Entry (CE) System and the shelters are used to quickly identify first-time homeless households. Regional access points and outreach sites ensure households are reached quickly.

2) CE sites use diversion strategies to resolve first-time housing instability before it results in actual homelessness, and CE access points, outreach teams, and the shelter system have access to limited flex funds to help first time homeless households rapidly self-resolve. To support system-level diversion capacity, the CoC provides prevention and diversion toolkits for communities to implement.

3) The CoC also supports local philanthropic partners funding prevention pilots. These pilots partner with the Arizona Housing Analytics Collaborative, a collaboration between Arizona's three public universities, to evaluate performance, impact, and outcomes. All pilot data is matched with data from 211, City of Phoenix's eviction prevention programs, and HMIS to enhance predictive modeling projects. In addition, the CoC will strengthen partnerships with organizations that offer short-term financial assistance and landlord engagement, which help households resolve housing-related issues before they result in loss of housing.

4) The CoC works with a privately funded research entity to perform a comprehensive gaps analysis on system flow in the CoC with recommendations on strengthening prevention. These analysis efforts include system modeling, which evaluates system effectiveness in reducing first time homelessness.

5) The CoC continues expanding partnerships with law enforcement, jails and prisons, and the health and behavioral health systems to reduce institutional discharges to homelessness, particularly for those entering homelessness for the first time. Through data sharing and the Arizona Medicaid agency's use of its 1115 Waiver, new jail in-reach programs are being developed to support housing-focused discharge planning and outcomes for persons diagnosed with a serious mental illness.

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)

Metric 1.2 shows a 2% decrease in the CoC's median Length of Time Homeless (LOTH), from 85 days in 2024 to 83 days in 2025 for emergency shelter (ES), safe haven (SH), and transitional housing (TH) programs, even though the average LOTH remained stable at 131 days. Data indicates that while long-term stayers remain in the system, most households move through system pathways in less than 90 days. LOTH decreased while ES, SH, and TH programs served 12% more people in 2025 than in 2024.

The CoC will continue to reduce LOTH by strengthening coordination, improving housing access, and using HMIS data for regional planning.

1) The CoC will support system partnerships and innovations, such as diversion and flex-funding pilots and Arizona State University's Shared Housing Project to quickly resolve homelessness. In 2027, the CoC will implement Standard Operating Procedures developed by Arizona's Medicaid agency, the three Arizona CoCs, and university researchers to improve services and reduce LOTH. The CoC is also strengthening connections with behavioral health and recovery providers, including 1115 Waiver partners, to expand treatment access for people with chronic and disabling conditions who remain long term in the system.

2) To promote system flow, the CoC is expanding workforce partnerships to develop employment pathways. The CoC is partnering with Maricopa County's Workforce Development Division to support bi-directional referrals and cross-system coordination. In addition, TH programs use mandatory service participation to support access to treatment, employment, and other services needed to exit homelessness.

3) The CoC uses HMIS data to monitor Coordinated Entry, shelter, and housing programs, and is working with the City of Phoenix and private funders on an HMIS system flow analysis to identify opportunities for improved efficiency. The CoC leads data sharing with Arizona's other two CoCs and with Arizona's Medicaid agency and behavioral health systems to strengthen coordination for high acuity and long-term homeless populations.

4) The CoC also supports partnerships between its funded providers, shelters, and funders. In 2026, shelter providers formed the Arizona Shelter Network to review shelter outcomes, set performance measures, compare service models, and identify opportunities to improve shelter effectiveness and move households more quickly to permanent housing.

	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?	56.00%
FY2026 CoC Application	Page 51	09/29/2026

Describe how you calculated the data for this response.**(limit 2,500 characters)**

The CoC ran a combined APR for October 1, 2024, to September 30, 2025, for all TH, RRH, and PSH projects. Using APR question Q23c, the CoC calculated total exits and exits to unsubsidized housing based on HUD's required destination categories. There were 5,076 total exits. Unsubsidized housing exits included staying or living with family, permanent tenure; staying or living with friends, permanent tenure; rental by client with no ongoing subsidy; and owned by client with no ongoing subsidy. These categories totaled 2,846 exits, resulting in an unsubsidized housing exit rate of 56 percent (2,846 out of 5,076).

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.	01/26/2026
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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	3,933	193	3,919	94.98%
2. Safe Haven (SH) beds	45	0	45	100.00%
3. Transitional Housing (TH) beds	1,891	77	1,178	59.86%
4. Rapid Re-Housing (RRH) beds	1,683	0	1,683	100.00%
5. Permanent Supportive Housing (PSH) beds	6,283	0	4,949	78.77%
6. Other Permanent Housing (OPH) beds	361	0	189	52.35%

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)

The CoC will increase bed coverage for TH, PSH, and OPH by targeting non-CoC/ESG-funded providers that are not required to use HMIS. Current coverage is 82.7 percent, largely due to non-participating HUD-VASH units, faith-based TH programs, and OPH providers operating outside CoC funding streams. The CoC will do the following:

For PSH, the CoC is working with Arizona's VA Medical Centers to implement bi-directional data sharing and HMIS software improvements to support integration of VAMC and VASH data into HMIS. This will address the largest source of missing HMIS participation.

For TH, lower coverage stems from faith-based TH programs that are not required to use HMIS. Building on NOFO efforts to integrate faith based, recovery, and TH projects, the CoC will conduct targeted outreach to encourage HMIS participation. If the NOFO results in awards for new faith-based TH projects, those new beds will be required to participate in HMIS, increasing future coverage.

For OPH, the CoC will conduct targeted outreach to these providers and their funders to encourage HMIS participation.

All recruitment efforts are supported by a transition in HMIS software which will reduce duplicate data entry and allow for more flexible data collection methods, thereby removing major barriers to HMIS participation.

The CoC's Collaborative Applicant (CA) and the HMIS Lead will use HIC data to identify non-HMIS participating TH/PH/OPH agencies. Staff from both entities will meet 1:1 with providers to promote HMIS participation, highlighting system-level benefits, improved coordination, and reduced administrative burden. New HMIS software features will support easier onboarding, better data integration and shared reporting tools. In 2026, the CoC Board approved HMIS data sharing with the VAMC, enabling bi-directional data sharing with the VA, the VA required VAMC coordination with the CoC and HMIS, and the VA's by name list matching. This is a precursor to VASH data integration. For OPH, the CA and HMIS lead will continue provider-level outreach and will, if necessary, involve funders to encourage HMIS participation. The CoC will develop HMIS tools, reporting supports, and direct coordination resources to incentivize HMIS engagement. Enhanced data-sharing capabilities in the new HMIS software will reduce dual data entry, overcoming a major objection to HMIS participation.

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	List of TH/RRH/PS...	09/28/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	List of CoC Prog...	09/28/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	Language from Pro...	09/29/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	Evidence of Coord...	09/28/2026
05. 1D-1. Local Competition Scoring Tool	Yes	Local Competition...	09/28/2026

06. 1D-2c. Local Competition Selection Results	Yes	Local Competition...	09/29/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	FY 2026 HDX Compe...	09/28/2026
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	Your CoC's Policy...	09/28/2026
11. Other	No		

Attachment Details

Document Description: List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment

Attachment Details

Document Description: List of CoC Program Projects and Number of Units that require Substance Abuse Treatment

Attachment Details

Document Description: Language from Project Supportive Service 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 Details

Document Description: FY 2026 HDX Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Your CoC's Policy or Statement to Advance Recovery

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/28/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/29/2026
1C. Coordination and Engagement	09/29/2026
1D. Project Review/Ranking	09/29/2026
2A. HMIS Implementation	09/29/2026
3A. Policy Initiatives	09/29/2026
4A. Attachments Screen	09/29/2026
Submission Summary	No Input Required

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

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

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

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

Applicant Name	Project Name	On-Site Treatment Available
*ABC	Casa De Salud	No
*NAC	Stepping Stones III	Yes
*NAC	Stepping Stones II	Yes
*ABC	SPC 189	No
*ABC	Casa Mia de Paz	No
*ABC	Another Chance	No
*NAC	Camelback Pointe	Yes
*ABC	HUD 6108	No
*ABC	SPC 293	No
*ABC	Casa de Luz	No
*UMOM	Next Step Housing 3 Consolidated	No
*LEAF	A New Leaf Domestic Violence Rapid Re- Housing Application	No
*SC Sojourner Center	Transitional Housing DV Bonus Project at Sojourner Center	No
Rooted in Grace Foundation	Health + Housing	Yes
*STF Save the Family	STF - Rapid Rehousing	No
*ABC	Transitional - PSH 2009	No
*ABC	Transitional - PSH 2016	No
*ABC	Transitional - SPC 151	No
*ABC	Transitional - Village	No
*ABC	Transitional PSH 3109	No
*CBI	CBI Transitional Housing Scattered Site	Yes
*CBI	Rio Transitional Housing	Yes
*UMOM	Next Step Housing TH	No
*STF Save the Family	STF Step Up Housing - Transitional Housing	No
Copa Health	Pathways of Hope	Yes
City Help	Transitional Pathways of Success	Yes
*LEAF	East Valley Men's Center - Transitional Housing	Yes
Mercy House Living Centers	Mercy House Transitional Housing Project	No
Total Projects with On-Site Treatment		9
Total Applicable Projects		28
Rate of Availability		32%

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

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

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

List of CoC Program Projects and Number of Units that Require Substance Abuse Treatment

Applicant Name	Project Name	SUD Treatment Units
*ABC	Casa De Salud	0
*NAC	Stepping Stones III	0
*NAC	Stepping Stones II	0
*ABC	SPC 189	0
*ABC	Casa Mia de Paz	0
*ABC	Another Chance	0
*NAC	Camelback Pointe	0
*ABC	HUD 6108	0
*ABC	SPC 293	0
*ABC	Casa de Luz	0
*UMOM	Next Step Housing 3 Consolidated	0
*LEAF	A New Leaf Domestic Violence Rapid Re- Housing Application	0
*SC Sojourner Center	Transitional Housing DV Bonus Project at Sojourner Center	0
Rooted in Grace Foundation	Health + Housing	0
*STF Save the Family	STF - Rapid Rehousing	20
*ABC	Transitional - PSH 2009	7
*ABC	Transitional - PSH 2016	7
*ABC	Transitional - SPC 151	6
*ABC	Transitional - Village	6
*ABC	Transitional PSH 3109	6
*CBI	CBI Transitional Housing Scattered Site	53
*CBI	Rio Transitional Housing	48
*UMOM	Next Step Housing TH	0
*STF Save the Family	STF Step Up Housing - Transitional Housing	14
Copa Health	Pathways of Hope	50
City Help	Transitional Pathways of Success	30
*LEAF	East Valley Men's Center - Transitional Housing	0
Mercy House Living Centers	Mercy House Transitional Housing Project	0
Maggie's Place	Recovery for Pregnant Moms Experiencing Homelessness	20
AZCEND	AZCEND Housing Stability and Supportive Service Project	28
Total SUD beds		295
2026 PIT SUD #		1324
Required 1 SUD bed for every 2 PIT SUD #		662
Current Ratio of SUD PIT #/units Available		4

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

1C-3. Language from Project Supportive Service Agreements

Service Participation Agreement _Template

Project Name: _____ Participant Name: _____

Unit/Room: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement outlines the supportive service expectations for participants residing in the project. These services are designed to help you obtain and maintain housing stability, increase income, improve health and well-being, and successfully exit to permanent housing. This agreement complies with Housing and Urban Development (HUD) 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals. Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Participant Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Work on your goals
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your case manager will also help with referrals, benefits, employment services, and other supports that fit your needs.

B. Work on Your Housing Stability Plan

You and your case manager will create a Housing Stability Plan. You agree to:

- Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc)
- Discuss strategies for achieving set goals and target dates for achievement
- Discuss the services available to you, when and how often they are provided and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- [for new TH:] Follow a weekly schedule reflecting up to 20 hours of options (or prorated hours if you are employed)
- Follow up on referrals and attend appointments
- Engage in housing retention activities, if necessary

- Turn in paperwork needed for recertification or income updates and
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that you or the program identifies as necessary to help you remain successful in housing, [for new TH: for at least 20h/week,] including but not limited to:

- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals

You will not be required to participate in disability-related services unless the purpose of the program is to provide substance use treatment, as allowed under federal regulations.

3. Program Responsibilities: What the Program Agrees To Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a case manager
- Help you understand your lease, if applicable
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need
- [for new TH:] Provide 20 hours per week of customized supportive services
- Services may include project-based, partner-delivered, or participant self-directed activities, and will be delivered on-site, off-site, or virtually
- Tailor services for you based on your need
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project or partner provided services, supports, and activities selected in collaboration with each participant, based on their goals, strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Health & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment, financial or other counseling, or income-support navigation

Maricopa Regional Continuum of Care FY26 CoC NOFO

- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services, **you may lose program assistance**, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services.
- Non-discrimination
- Ability to file grievances without retaliation
- [for new TH] Request an exemption from or proration of service participation requirements if you are employed, over the age of 62 and/or have a qualifying disability under 24 CFR 8.3 or developmental disability under 24 CFR 578.3

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the responsibilities of the program and that I may ask questions at any time.

Signatures:

Participant: _____

Date: _____

Staff: _____

Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.

Service Participation Agreement _Projects with SUD Purpose Template

Project Name: _____ Participant Name: _____

Unit/Room: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement applies to projects whose purpose is to provide Substance Use Disorder (SUD) treatment services. Your participation in SUD-related services is required under the Housing and Urban Development 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals. Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Client Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Work on your goals
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your case manager will also help with referrals, benefits, employment services, and other supports that fit your needs.

B. Work on Your Housing Stability Plan

You and your case manager will create a Housing Stability Plan. You agree to:

- Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc)
- Discuss strategies for achieving set goals and target dates for achievement
- Discuss the services available to you, when and how often they are provided and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- [for new TH:] Follow a weekly schedule reflecting up to 20 hours of options (or prorated hours if you are employed)
- Follow up on referrals and attend appointments

- Engage in housing retention activities, if necessary
- Turn in paperwork needed for recertification or income updates and
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that the program identifies as necessary to help you remain successful in housing, [for new TH: for at least 20h/week,] including but not limited to:

- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals

D. Participate in SUD Treatment

Part of your program participation you agree to take part in:

- Scheduled individual or group counseling or treatment sessions
- Recovery-focused case management
- Required assessments and plan updates and
- Safety and sobriety expectations in shared spaces

Your level of participation will match your stage of change and your treatment plan. Staff will work with you in a supportive, person-centered way.

D. Participate in On-Site SUD Treatment Services (if applicable)

If this program provides on-site SUD treatment and you have a SUD, you may be required to take part in treatment per local CoC policies and federal regulations.

What “On-Site Substance Use Treatment” Means: SUD treatment and recovery services are provided at the project location, at a co-located service office, in a private meeting space within the building, or through telehealth or other virtual service modalities that the participant can access from their unit, a private project-supported space, or another appropriate location connected to the project, by qualified staff or through a formal partnership with a licensed SUD provider. These services may include one or more of the following:

- Case management focused on SUD treatment and recovery needs
- Clinical assessment and treatment planning for SUD
- Peer recovery support services
- Individual or group counseling using evidence-based approaches
- Medication-Assisted Treatment (MAT) or medication management
- Relapse prevention, psychoeducation, and structured recovery groups and
- Warm handoffs to higher levels of care when needed

3. Program Responsibilities: What the Program Agrees To Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a case manager
- Help you understand your lease, if applicable
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need.
- [for new TH:] Provide 20 hours per week of customized supportive services
- Services may include project-based, partner-delivered, or participant self-directed activities, and will be delivered on-site, off-site, or virtually
- Tailor services for you based on your need
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project or partner provided services, supports, and activities selected in collaboration with each participant, based on their goals, strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Health & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment, financial or other counseling, or income-support navigation
- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services, **you may lose program assistance**, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services, unless the purpose of the program is to provide SUD treatment services.
- Non-discrimination
- Ability to file grievances without retaliation
- [for new TH] Request an exemption from or proration of service participation requirements if you are employed, over the age of 62 and/or have a qualifying disability under 24 CFR 8.3 or developmental disability under 24 CFR 578.3

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the responsibilities of the program and that I may ask questions at any time.

Signatures:

Participant: _____

Date: _____

Staff: _____

Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.

On-Site Substance Use Treatment

Definition

On-site substance use treatment refers to the delivery of clinically appropriate Substance Use Disorder (SUD) treatment and recovery services at a project location by qualified behavioral health professionals or certified peer recovery staff, or through a formal partnership with a licensed SUD treatment provider that provides services at the project site on a scheduled and consistent basis. These services must align with SAMHSA-recognized evidence-based practices and state licensure requirements and must support participant engagement across the stages of change.

Core Components

A project may be considered to provide on-site substance use treatment if it offers, at minimum, **one or more** of the following services at the project location:

- **Case management** or service coordination specifically addressing SUD treatment and recovery needs
- **Clinical assessment and treatment planning** for SUD
- **Individual and/or group counseling** using evidence-based modalities (e.g., CBT, MI, CM)
- **Peer recovery support services** delivered by certified peer supporters
- **Medication-Assisted Treatment (MAT)** or medication management delivered:
 - directly by licensed medical staff on-site, **or**
 - via telehealth with clinical staff providing on-site support
- **Relapse prevention**, psychoeducation, and structured recovery groups
- **Facilitated referral and warm handoff** to higher levels of care (IOP, detox, inpatient, residential)

Acceptable Delivery Models

The following are considered *on-site* when documented:

- Services provided at the property on a regular schedule by licensed clinicians or certified peers who are employed by the project or a partner provider
- Telehealth sessions conducted at the project site with clinical facilitation
- A combination of on-site direct services and scheduled on-site availability from a partner agency

Minimum Expectations for Documentation

Projects claiming on-site SUD treatment must maintain:

1. A written description of services delivered at the site
2. Licensure or certification documentation of the treating agency or staff, consistent with state requirements
3. A schedule or service plan showing regular on-site availability
4. A formal partnership agreement or MOU (if using partner providers)
5. A **Service Participation Agreement** that complies with 24 CFR 578.75(h) and CoC Program funding requirements.

Service Participation Agreement _Projects with SUD Purpose Template

Project Name: _____ Participant Name: _____

Unit/Room: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement applies to projects whose purpose is to provide Substance Use Disorder (SUD) treatment services. Your participation in SUD-related services is required under the Housing and Urban Development 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals. Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Client Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Work on your goals
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your case manager will also help with referrals, benefits, employment services, and other supports that fit your needs.

B. Work on Your Housing Stability Plan

You and your case manager will create a Housing Stability Plan. You agree to:

- Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc)
- Discuss strategies for achieving set goals and target dates for achievement
- Discuss the services available to you, when and how often they are provided and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- [for new TH:] Follow a weekly schedule reflecting up to 20 hours of options (or prorated hours if you are employed)
- Follow up on referrals and attend appointments

- Engage in housing retention activities, if necessary
- Turn in paperwork needed for recertification or income updates and
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that the program identifies as necessary to help you remain successful in housing, [for new TH: for at least 20h/week,] including but not limited to:

- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals

D. Participate in SUD Treatment

Part of your program participation you agree to take part in:

- Scheduled individual or group counseling or treatment sessions
- Recovery-focused case management
- Required assessments and plan updates and
- Safety and sobriety expectations in shared spaces

Your level of participation will match your stage of change and your treatment plan. Staff will work with you in a supportive, person-centered way.

D. Participate in On-Site SUD Treatment Services (if applicable)

If this program provides on-site SUD treatment and you have a SUD, you may be required to take part in treatment per local CoC policies and federal regulations.

What “On-Site Substance Use Treatment” Means: SUD treatment and recovery services are provided at the project location, at a co-located service office, in a private meeting space within the building, or through telehealth or other virtual service modalities that the participant can access from their unit, a private project-supported space, or another appropriate location connected to the project, by qualified staff or through a formal partnership with a licensed SUD provider. These services may include one or more of the following:

- Case management focused on SUD treatment and recovery needs
- Clinical assessment and treatment planning for SUD
- Peer recovery support services
- Individual or group counseling using evidence-based approaches
- Medication-Assisted Treatment (MAT) or medication management
- Relapse prevention, psychoeducation, and structured recovery groups and
- Warm handoffs to higher levels of care when needed

3. Program Responsibilities: What the Program Agrees To Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a case manager
- Help you understand your lease, if applicable
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need.
- [for new TH:] Provide 20 hours per week of customized supportive services
- Services may include project-based, partner-delivered, or participant self-directed activities, and will be delivered on-site, off-site, or virtually
- Tailor services for you based on your need
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project or partner provided services, supports, and activities selected in collaboration with each participant, based on their goals, strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Health & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment, financial or other counseling, or income-support navigation
- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services, **you may lose program assistance**, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services, unless the purpose of the program is to provide SUD treatment services.
- Non-discrimination
- Ability to file grievances without retaliation
- [for new TH] Request an exemption from or proration of service participation requirements if you are employed, over the age of 62 and/or have a qualifying disability under 24 CFR 8.3 or developmental disability under 24 CFR 578.3

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the responsibilities of the program and that I may ask questions at any time.

Signatures:

Participant: _____

Date: _____

Staff: _____

Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.

On-Site Substance Use Treatment

Definition

On-site substance use treatment refers to the delivery of clinically appropriate Substance Use Disorder (SUD) treatment and recovery services at a project location by qualified behavioral health professionals or certified peer recovery staff, or through a formal partnership with a licensed SUD treatment provider that provides services at the project site on a scheduled and consistent basis. These services must align with SAMHSA-recognized evidence-based practices and state licensure requirements and must support participant engagement across the stages of change.

Core Components

A project may be considered to provide on-site substance use treatment if it offers, at minimum, **one or more** of the following services at the project location:

- **Case management** or service coordination specifically addressing SUD treatment and recovery needs
- **Clinical assessment and treatment planning** for SUD
- **Individual and/or group counseling** using evidence-based modalities (e.g., CBT, MI, CM)
- **Peer recovery support services** delivered by certified peer supporters
- **Medication-Assisted Treatment (MAT)** or medication management delivered:
 - directly by licensed medical staff on-site, **or**
 - via telehealth with clinical staff providing on-site support
- **Relapse prevention**, psychoeducation, and structured recovery groups
- **Facilitated referral and warm handoff** to higher levels of care (IOP, detox, inpatient, residential)

Acceptable Delivery Models

The following are considered *on-site* when documented:

- Services provided at the property on a regular schedule by licensed clinicians or certified peers who are employed by the project or a partner provider
- Telehealth sessions conducted at the project site with clinical facilitation
- A combination of on-site direct services and scheduled on-site availability from a partner agency

Minimum Expectations for Documentation

Projects claiming on-site SUD treatment must maintain:

1. A written description of services delivered at the site
2. Licensure or certification documentation of the treating agency or staff, consistent with state requirements
3. A schedule or service plan showing regular on-site availability
4. A formal partnership agreement or MOU (if using partner providers)
5. A **Service Participation Agreement** that complies with 24 CFR 578.75(h) and CoC Program funding requirements.

RAPID RE-HOUSING NEXT STEPS AGREEMENT

Client Name: _____ Date: _____

Initials	
	I understand that this program is a short-term rental/utility assistance program, and my assistance is individualized, specifically tailored for my needs, and is geared toward assisting me with gaining and maintaining self-sufficiency as quickly as possible. The amount of initial assistance will be discussed during your Housing Admission appointment and then any additional assistance is determined on a month-to-month basis. The program does have a maximum income limit for additional assistance, which is the total household income cannot exceed 30% AMI. This limit will be discussed with your Housing Case Manager after move in.
	You must apply for all governmental assistance for which your family is eligible. You will be responsible for a percentage of your rent starting at month 3. If you enter the program without income, you will be expected to provide your Case Manager with weekly updates on job searching and participate in employee services. Once you have obtained permanent employment, you will be required to bring in the following information on employer letterhead: date of hire, days and hours of work, and rate of pay. Afterwards, you will be required to submit monthly check stubs to verify employment.
	I understand that this program has a drug free policy. You will remain free of drugs while participating in the program. If you have a history of substance abuse, you will discuss the progress of your recovery plan with your Case Manager at weekly meetings. Staff may require participation in recovery-based programming.
	I understand that I must always provide staff with true and complete information. I understand that A New Leaf staff relies upon the information I give them, and I promise that it will always be accurate.
	I will be scheduled to attend a Housing Admission Appointment with HOM Inc.- ALL household members over the age of 18 are required to attend. Once I attend this meeting, I understand that I will have 60 days to locate housing- I will stay in contact with my Housing Navigator during this time, providing (at a minimum) a weekly update of my progress.
	Once I have located housing, I understand that the unit will have to be inspected and approved by HOM Inc. Once the unit passes inspection, I understand that I can then sign my lease and move into my unit. IF utilities are not included, I understand that I will have to set up my utilities and then provide my case manager with the account number and deposits amounts as soon as possible so the bill can be paid. I also understand that once I sign a lease, it is a legal contract, and A New Leaf CAN NOT exit you from the lease. Landlord/Tenant Law must be followed.
	I understand that I must follow rules outlined in the terms of my lease at all times. Residents are responsible for ensuring that all guests comply with the property's rules and regulations as well as A New Leaf program expectations. The lease will be reviewed with client at time of move in and any lease violations can result in program termination.
	I understand that A New Leaf staff have the right to inspect my apartment at any time. You must keep my apartment clean. You must also dispose of your garbage and recyclable materials properly. You are responsible for any damage to your apartment and for any damage you may cause elsewhere on the premises. Staff may perform a health and safety check at each monthly check in.
	I understand that I must actively participate in my Housing Stability Plan. This plan will be created within the first 30 days of your move-in. It will define goals and strategies that are tailored to your family's needs. It will cover the following topics: • Education/Employment. • Parent/Child program. • Life skills

	At review sessions monthly; you and staff will discuss your progress, strengths, and areas in need of improvement. You will agree on adjustments to the goals in your Housing Stability Plan, if necessary. Upon reaching an agreement on such a change, you and staff will sign a new plan.
	I understand that I must keep my Rapid Re-Housing Case Manager updated with my current contact information and have contact with my Case Manager at least once a month so a determination can be made for continued assistance. If you know that you will miss a meeting, you must notify staff 24 hours prior and explain your reason to the Case Manager. In an emergency, you must notify staff as soon as possible. You must notify the Program Staff in advance of any extended leave away from the program
	I understand that I am responsible for all late fees for rent and utilities. I understand that if I exceed my utility allowance at any point, I am responsible for the difference.
	I understand that I will notify my Rapid Re-Housing Case Manager of any lease violations or concerns and that I will not sublet or allow anyone to move into my unit that has not been authorized by property management.
	I understand that when leaving a message for my case manager I will speak clearly, leave my name, number, and the reason for the call. ALL case managers are required to return calls within one business day.
	RRH Case Managers provide clients with household items when they become available through charitable donations from the community. RRH is released of all liability of the items donated to you once you have accepted them. All items are AS IS and will not be repaired or cleaned by A New Leaf.
	When possible RRH provides clients with assistance with moving items into their apartments. A New Leaf is released of all liability to the items during the move.
	When possible RRH provides transportation for clients to assist with apartment searches, employment opportunities, or other appointments that promote the clients' housing stability. A New Leaf is released of all liability for any client or any member of the household during transportation.

You certify that you have read and understand the A New Leaf's Program Agreement and agree to abide by its terms. You agree that any violation of these terms will subject you (upon discretion of the Program Director) to termination from the Program. You asked a staff member for clarification of the portions of the agreement, if any, that you did not understand.

Reviewed at Intake: Client Signature: _____ Date: _____

CM Signature: _____ Date: _____

Reviewed after move in: Client Initials: _____ Date: _____ CM Initials: _____

Service Participation Agreement _Template

Project Name: _____ Participant Name: _____

Unit/Room: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement outlines the supportive service expectations for participants residing in the project. These services are designed to help you obtain and maintain housing stability, increase income, improve health and well-being, and successfully exit to permanent housing. This agreement complies with Housing and Urban Development (HUD) 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals. Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Participant Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Work on your goals
- Remain Drug Free
- Obtain and Maintain Employment
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your case manager will also help with referrals, benefits, employment services, and other supports that fit your needs.



868 East University Drive, Mesa, AZ 85203 | (480) 464-4648 | TurnaNewLeaf.org
501(c)3 Organization | EIN: 86-0256667 | QCO Code: 20075

To request this document in alternative format or for further information about this policy, contact the Division of Aging and Adult Services at 602-542-4446; TTY/TDD Services: 7-1-1. Free language assistance for DES services is available upon request.

B. Work on Your Housing Stability Plan

You and your case manager will create a Housing Stability Plan. You agree to:

- Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc)
- Discuss strategies for achieving set goals and target dates for achievement
- Discuss the services available to you, when and how often they are provided and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- Follow a weekly schedule reflecting up to 20 hours of options (or prorated hours if you are employed)
- Follow up on referrals and attend appointments
- Engage in housing retention activities, if necessary
- Turn in paperwork needed for recertification or income updates and
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that you or the program identifies as necessary to help you remain successful in housing including but not limited to:

- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals

You will not be required to participate in disability-related services unless the purpose of the program is to provide substance use treatment, as allowed under federal regulations.



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3. Program Responsibilities: What the Program Agrees To Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a case manager
- Help you understand your lease, if applicable
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need
- Provide 20 hours per week of customized supportive services
- Services may include project-based, partner-delivered, or participant self-directed activities, and will be delivered on-site, off-site, or virtually
- Tailor services for you based on your need
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project or partner provided services, supports, and activities selected in collaboration with each participant, based on their goals, strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Health & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment, financial or other counseling, or income-support navigation
- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy



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B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services, **you may lose program assistance**, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services.
- Non-discrimination
- Ability to file grievances without retaliation
- Request an exemption from or proration of service participation requirements if you are employed, over the age of 62 and/or have a qualifying disability under 24 CFR 8.3 or developmental disability under 24 CFR 578.3



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a new leaf

helping families, changing lives

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the responsibilities of the program and that I may ask questions at any time.

Signatures:

Participant: _____

Date: _____

Staff: _____

Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.



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Program Agreement



Participants: _____ Apt. # _____

Starting on: _____ Ending no later than: _____

A New Leaf's Transitional Housing Program is a two-year, drug and alcohol-free, transitional housing program operated by A New Leaf, a nonprofit corporation. We have high expectations for you, and you should have high expectations for us. This Program Agreement ("Agreement"), which covers Program terms and residential requirements for living at A New Leaf's TH Program, is a legal contract that sets out the terms of your participation in the Program. Please read through each statement. Your signature at the end will indicate that you agree with the entire agreement.

Summary

This summary highlights selected provisions of the Program Agreement. It does not cover every term or detail of participation in the Program and is intended for informational purposes. The complete and final terms are set out in the Agreement, beginning with Section 1 below.

- 1. Program Requirements:** Section 1 of the Agreement is about Program activities. At A New Leaf's TH, you will prepare for independent living while working closely with staff and participating in education or job training programs. You will spend 20 hours per week toward meeting Program goals, and you will attend regular meetings with your case manager and other staff.
- 2. Financial Requirements:** Section 2 sets out your financial obligations. You must apply for all governmental assistance for which your family is eligible. You will pay a percentage of your income as a housing fee, and save a percentage of your income to prepare for independent living.
- 3. Occupancy Requirements:** We hope you find A New Leaf's TH to be a comfortable and supportive place while you strengthen your independent living skills. As you read Section 3, which sets out the rules for living here, it is important to understand that you are a licensee of A New Leaf's TH, and not a tenant. You are not signing a lease, A New Leaf is not your landlord, and residency at A New Leaf's TH will at no time confer tenancy rights.
- 4. Children:** Section 4 contains rules for residents with children. You must obtain medical care for your children and keep young children under your supervision any time they are not in school, childcare, or after-school programs. Physical punishment of children is not allowed at any time or for any reason.
- 5. Conflicts, Discipline, and Dispute Resolution:** A New Leaf's TH is a Program with clearly defined goals and expectations. The rules described in Section 5 are designed to help you achieve these goals. If you cannot follow the Program rules, you can be dismissed from the Program, and you will not be able to continue living at A New Leaf's TH. Section 5 sets out more information about our discipline and grievance processes.

6. **Consents:** Section 6 contains agreements related to your children's participation in A New Leaf's TH programs; drug testing; your family's medical care; participation in recovery programs; an agreement allowing for the splitting of funds if a member of a couple leaves the Program separately; policies related to your use of the computers and the Internet connection in the facility; and an agreement allowing A New Leaf to use your image, voice, story, or name, for purposes of advancing the Program. There are some separate consent forms you must sign in addition to this agreement.
7. **Confidentiality:** Section 7 sets out the important confidentiality rules that apply to both of us, for your benefit and that of the other participants in the Program.
8. **Other Requirements:** Section 8 outlines car ownership policies.
9. **Assumption of Risk, Indemnification, Waivers:** In Section 9, you acknowledge the risks and challenges of living in a transitional housing setting, waive legal claims, promise to be responsible for your conduct if it damages A New Leaf's Property, and allow A New Leaf staff to perform first aid or seek medical assistance for you if necessary.
10. **General Provisions:** Section 10 includes common provisions of a contract, including making clear that the Program Agreement is the key document setting out Program terms.
11. **Exhibits:** Exhibit A sets out the fees for which you are responsible. Exhibit B describes the Level System and lays out the requirements in a one-page comprehensive table. Exhibit C provides information about the Transitional Housing Misconduct Act.

1. Program Requirements

1.1 Purpose of A New Leaf's Transitional Housing Program

A New Leaf's TH Program provides a structured Program environment where you and your family can live for up to two years while you develop the skills needed to maintain permanent housing, obtain employment that pays a living wage, and live independently. It is not intended as subsidized housing while you maintain a low-paying job.

1.2 Program Expectations

(a) Overview

You will spend 40 hours each week working towards Program goals. These hours will include work, school and meetings with staff. Your assigned case manager will evaluate your situation and discuss with you Program expectations and the choice of services for you. We will make the final decision regarding those services. You will attend meetings with your case manager at least once a week, as well as attend other scheduled meetings and workshops.

(b) Housing Stability Plan

Your Housing Stability Plan, to be completed within the first 30 days of your move-in, defines goals and strategies that are tailored to your family's needs. It will cover the following topics:

- **Permanent Housing.**
- **Education/Employment.**
- **Parent/Child program.**
- **Life skills**

(c) Education and Job Training Programs

You will be enrolled in an educational or job training program. Once you have obtained permanent employment, you will be required to bring in the following information on employer letterhead: date of hire, days and hours of work, and rate of pay. Afterwards, you will be required to submit monthly check stubs to verify employment.

(d) Case Management, Education and Employment Meetings

- **Weekly:** Your Case Manager will schedule weekly appointments for you to discuss your goals, including those related to education, training and employment; permanent housing and independent living skills; your children's school progress; medical care; and money management.
- **Monthly:** At review sessions monthly; you and staff will discuss your progress, strengths, and areas in need of improvement. You will agree on adjustments to the goals in your Housing Stability Plan, if necessary. Upon reaching an agreement on such a change, you and staff will sign a new plan.

(e) Group Meetings

In addition to individual and family meetings described above, you will attend weekly participant meetings, and also emergency meetings as required by staff. The weekly meetings are as follows:

- **TBD**

Client may change meeting dates and times and will advise you of any such changes.

(f) Substance Abuse Recovery

If you have a history of substance abuse, you will attend weekly recovery group meetings, and enroll and actively participate in a treatment program. Staff may test you if they suspect that you may be using drugs or alcohol.

(g) Attendance and Punctuality at Meetings

You must be on time for all meetings and stay until they are over. You are considered absent if you are more than 15 minutes late, unless you notify staff in advance that you will be late. If you know that you will miss a meeting, you must notify staff 24 hours prior and explain your reason to the Program Director. In an emergency, you must notify staff as soon as possible. If you miss more than two meetings in a 90-day period without an approved excuse, such as a confirmed medical appointment or an employment obligation, you will be subject to disciplinary procedures. The Program Director or other staff may grant exceptions to these requirements.

1.3 Immediate Termination of Participation

Some rules are so important that a single violation may result in immediate termination of Program participation and residency at A New Leaf's TH. These include:

- **Violence, threats, or possession of weapons.** If a violent incident occurs, including threats or domestic violence, Staff will call the police and file charges. No weapons are allowed on the premises. Staff may confiscate any articles they believe are being used in a threatening or combative manner.
- **Possession, use, or sale of illegal drugs or alcohol.** Staff may terminate your residency for possession, sale, or use of any illegal drugs or alcohol, or for being under the influence of these substances while on the premises. No one under the influence of drugs or alcohol is allowed on the premises.
- **Disruptive behavior.** Staff may terminate your residency for any activities that unreasonably interfere with the comfort, safety or enjoyment of other residents, staff, or neighbors, including theft; willful destruction of property; breach of confidentiality; or any felonious activity.

This list does not include every rule that you must follow. Other rules are set out in this Agreement.

1.4 Truthfulness

You will always provide staff with true and complete information. You understand that A New Leaf staff relies upon the information you give them, and you promise that it will always be accurate.

2. Financial Requirements

2.1 Government Assistance

You must apply for all governmental assistance for which your family is eligible.

2.2 Monthly Fees

You will pay a percentage of your monthly income each month as a Program participation and housing fee. This percentage is set out in Exhibit A.

2.2 Savings

You will save a percentage of each month's income in order to prepare for the costs of maintaining permanent housing and living independently. This percentage is set out in Exhibit A. These savings will be held in a bank account, either by Client or in your own name. If you open your own bank account, the Program Director will ask you to verify your balance monthly.

2.3 Failure to Meet Financial Obligations

Failure to pay monthly fees on time may result in late fees and/or disciplinary proceedings as set out in Section 5.1.

3. Occupancy Requirements

3.1 Length of Residency

Your residence at A New Leaf's TH will not exceed twenty-four (24) months. You understand that A New Leaf may dismiss you from the Program and terminate your residency for violating the rules in this Agreement. You can leave the Program at any time by giving staff at least 30-days written notice.

3.2 Access to A New Leaf's TH Premises and Apartments

(a) Not a tenancy

Residence at A New Leaf's TH Program is a central component of the Program. You understand that you are a licensee of A New Leaf, and not a tenant. You are not signing a lease, A New Leaf is not your landlord, and residency at A New Leaf's TH will at no time confer tenancy rights. A New Leaf may terminate your residency for violation of this Agreement. A New Leaf retains the right of control over and access to all A New Leaf TH apartments.

(b) Probationary period

Your participation in the Program is probationary for the first 60 days. A New Leaf may extend this period at its discretion. During the probationary period, if staff determines that you are not able to participate fully in the Program, you will be dismissed. At the end of the probationary period, if you have complied with all Program rules set out in this Agreement and all goals set out in your Housing Stability Plan, you will be accepted as a Program participant and resident of A New Leaf's TH Program.

(c) Abandonment of premises

You must notify the Program Staff in advance of any extended leave away from the program. A New Leaf may discard items belonging to clients who are missing from the program for more than 72 hours without notice. Absent prior notice, Client may not hold your apartment beyond this point.

3.3 Apartment Rules

(a) Cleanliness

You must keep your apartment clean. You must also dispose of your garbage and recyclable materials properly.

(b) Damages and Repairs

You are responsible for any damage to your apartment and for any damage you may cause elsewhere on the premises. Deductible expenses include, but are not limited to, physical repairs, furniture repair, key replacement, lock changes and stolen property.

(c) Entry

A New Leaf staff has the right to inspect your apartment at any time. Staff may perform a health and safety check of each apartment each month. On occasion, potential or current funders may tour A New Leaf's TH Program. This may include a tour of your living quarters. A New Leaf employees and agents may also enter and inspect your apartment and common areas at any time to check that you are in compliance with this Agreement. In an effort to prepare you for living in a private apartment complex, as a courtesy, we will try to give 24-hours advance notice to you.

The presence of A New Leaf staff at your apartment will not limit or affect in any way your obligation to comply with this Agreement. This Section also does not impose any duty on A New Leaf to inspect your apartment, report to anyone the results of any such inspection, or assume any liability of any kind arising from engaging or not engaging in such an inspection.

(d) Keys and Locks

You may not duplicate keys, or lend them to children or visitors. For safety purposes, please inform staff of lost card keys, apartment keys and mailbox keys immediately.

If you lose your card key, staff will charge you a replacement fee, which will increase if you lose your card key subsequent times. These fees are set out in Exhibit A.

If you lose your apartment key, staff will charge a percentage of the replacement cost, which will increase each time you lose your apartment key. These fees are set out in Exhibit A.

Locks may not be placed on any doors or windows except by A New Leaf .

(e) Fire Safety

For safety reasons, you must maintain a clear exit path to the front door or window of each room at all times, and your front door should be able to open completely.

You and all members of your family should know which doors exit to the outside, and where the fire extinguishers are located throughout the premises. Staff will conduct regular fire drills and your participation in the drills is mandatory.

More information on fire safety is provided in the Emergency Procedures document A New Leaf will provide you.

(f) Pets- TBD

You may not have a pet.

(g) Inspection on Move-Out

When you leave the Program and move out, you will schedule your departure with the staff, and you may be asked to sign a Move-Out Contract as part of the departure process. Staff will conduct the final inspection/inventory of your room and apartment. You agree to leave the premises neat and in clean condition when you vacate, and to return key(s) to the staff. Staff will discard any personal property that you leave.

3.4 Client House Rules

(a) Chores

You will participate in the maintenance, cleanliness and safety of the premises. Each week, staff will create a chore list, assign you chores, and monitor that you are completing chores.

(b) Regular guests and visiting hours

You may have a maximum of two adult guests per day. You are responsible for the behavior of your guests. A New Leaf may ban any guest causing problems or disruptions to the household or any other part of the premises. You may not leave guests alone in your apartment or any other part of the premises. You will escort your guests to and from your apartment. Visiting hours are as follows:

TBD

If you want an exception to these hours, you must obtain staff approval in advance.

(c) Overnight guests

Overnight guests are not allowed

(d) Quiet Hours

You will keep voices, televisions, radios, and other noise-making devices at a low volume during quiet hours. Quiet hours are as follows:

Sunday – Thursday	8 pm – 8 am
Friday – Saturday	9 pm – 8 am

(e) Smoking

Smoking is only permitted in designated areas.

(f) Trash

Trash will be discarded appropriately and regularly. You must not throw any items out of apartment windows. You must not flush diapers down the toilets, and you may be charged a fine if you flush any trash other than toilet paper down your toilet. Client may also impose a fine or recover expenses for the repair and/or replacement of the garbage disposal. These fees are set out in Exhibit A.

4. Children

4.1 Special Rules Regarding Children

(a) Responsibility for children

Children under the age of 13 must be under the supervision of their parents or legal guardians at all times except when they are at school or participating in childcare or after-school activities. Child(ren) under the age of 13 must not be left alone in the apartment and may not be permitted to play outdoors unless they are adequately supervised. Children over the age of 13 may be allowed to be in their apartment alone with their parent's and the Program's approval, only during business hours. There must be a valid reason that a parent is not at home, either due to school or to work. Your case manager will monitor this arrangement at monthly meetings with you and your child(ren). Children of any age are not allowed visitors unless supervised by their parent and the visit occurs during regular visiting hours.

(b) Punishment of children and child abuse

Physical punishment of children is not allowed at any time or for any reason. No spanking, hitting, slapping, jerking or any other behavior that may hurt a child is allowed. The law requires that anyone suspected of child abuse be reported to Children's Emergency Response Services. Any incidents of child abuse may result in termination of participation in the Program and residency at A New Leaf's TH Program.

(c) Children's behavior

Parents are responsible for the safety and behavior of their children at all times, as well as for any damage they might cause. Children will not physically or verbally abuse other children or adults. Disruptive behavior by children may result in termination of residency at A New Leaf's TH Program.

(d) Medical Care

Parents are expected to obtain regular medical attention for their children. If a child remains home because of illness, one parent must stay at home with him/her or arrange for appropriate childcare. Pregnant women are expected to obtain appropriate prenatal care.

(e) Babysitting

Babysitting another residents children is not allowed.

(f) Safety

You must maintain your apartment in a safe condition for your children. Keep all dangerous or poisonous items, including cleaning products, medications, mouthwash, matches or lighters, cosmetics, toiletries or sharp objects, out of reach of young children, such as by placing these items on the

highest shelf in the closet or kitchen. If possible, place childproof cabinet locks on all cabinets that contain dangerous or poisonous items. All food items should be tightly sealed when not in use. If you have small children, be sure to place electrical outlet covers on all sockets.

(g) Dress

You and your children must be properly dressed whenever you are in the common areas.

4.2 Childcare Programs

(a) N/A

5. Conflicts, Discipline, and Dispute Resolution

5.1 Disciplinary Proceedings

(a) Introduction

The Program has clearly defined goals and expectations. The rules described in this Agreement are designed to help you achieve these goals. A New Leaf's TH Program is also a community that is built upon respect for the rights of others. Program rules, including the disciplinary process, are designed to both help you succeed and ensure that other's rights are maintained.

(b) Reminders

A violation of any of the rules described in this Agreement may result in a Reminder. Staff will document Reminders in your file.

(c) Write-ups

Once you have received a Reminder, for the next 90 days any violation of any rule described in this Agreement may result in a Write-up.

(d) Behavioral Contracts; Dismissal

If you accumulate 3 Write-ups in a 90-day period, you will be placed on a Behavioral Contract. A Behavioral Contract results in a probation period, in effect for up to 90 days, during which any further violations may result in immediate termination of residency at A New Leaf's TH and dismissal from the Program. Dismissal means that you must move out of A New Leaf's TH and that you will no longer receive services from us under the Program.

5.2 Grievance Procedure

(a) Agency Grievance Policy provided at Move in.

5.3 Conflict Resolution

While conflict is a normal part of all healthy relationships, how you deal with conflict will partially determine whether or not you can remain in the Program. Any threat of a physical nature and/or verbal abuse toward staff or any participant will result in immediate termination from the Program. If you cannot resolve a conflict with another party yourself, ask staff to mediate. If he/she is unable to help you with reaching a resolution, you should bring the discussion to the Program Director. If the conflict concerns staff, please feel free to go directly to the Program Director.

5.4 Client' Rights

(a) Agency Policy provided at Move In

6. Consents

TBD based on program design

(a) Program Recovery Agreement

You agree that upon entering A New Leaf's TH you will work with your Case Manager to achieve the following recovery plan goals:

- You will remain free of alcohol and other drugs while living at A New Leaf's TH Program
- You will see a counselor who will work with you on issues related to abstinence from alcohol and/or other drugs.
- You will attend 12-steps meetings (for example Alcoholics Anonymous or Narcotics Anonymous) or other recovery programs as discussed with the Case Manager.
- You will select and work with a sponsor
- You will discuss the progress of your recovery plan with your Case Manager at your weekly action plan meeting.

You have read, understand, and agree to follow all the conditions above. You further understand that non-compliance could jeopardize your participation in the Program.

6.2 Computer Policy

Agency Equipment Loan agreement provided as necessary

7. Confidentiality

Agency Policy provided at Move In

8. Other Requirements

8.1 Transportation

Client House is well located for using public transportation. If you own a car, you must have current registration and insurance for the car and you must have a valid driver's license.

9. Assumption of Risk, Indemnification, and Waivers

9.1 Awareness and Assumption of Risk

You understand that your participation in the Program and presence at A New Leaf facilities have inherent risks that may arise from many factors, including your own actions or inactions, or the actions or inactions of A New Leaf, its directors, officers, employees, and agents, and other participants and their children. These risks may include, without limitation, living in a close residential setting with other individuals in a period of transition in their lives, which may include overcoming trauma, substance abuse, psychological or emotional problems, financial distress, and homelessness. You may also be around the small children of other participants, who can behave unpredictably, and you recognize that the Program serves both men and women. You also understand that A New Leaf is not responsible for the conduct of other participants or their children and does not provide a supervised living environment, meaning that you, other participants, and sometimes their children live independently and interact with each other directly. You assume full responsibility for any and all risks of bodily injury, death, or property damage caused by or arising directly or indirectly from your occupancy at A New Leaf's TH, presence at a A New Leaf facility, and participation in the Program, regardless of the cause.

9.2 Indemnification

You will defend, indemnify and hold A New Leaf and its directors, officers, employees, agents, and assigns harmless against all claims, liabilities, losses, damages, expenses, and attorneys' fees (together, "liabilities"), arising from any death, property damage, or injury of any nature whatsoever that may be suffered by any other participant in the Program, A New Leaf, A new Leaf staff member, external services provider, neighbor of A New Leaf, or any other third party which may arise directly or indirectly from (a) your occupancy of or conduct while at A New Leaf TH or other A New Leaf property or your participation in the Program, or (b) your breach of this

Agreement, except to the extent the liability is caused by the gross negligence or willful misconduct of the relevant A New Leaf Party.

9.3 Waiver of Liability

You waive and release any and all claims against A New Leaf, its directors, officers, employees, and agents for any liability, loss, damages, injury, claims, expenses, and attorneys' fees (collectively, "Liabilities") that may be suffered by you, your family members or your guests, which may arise, directly or indirectly, from your occupancy of or conduct while at A New Leaf's TH or other A New Leaf property, or your participation in the Program, except to the extent the injury, death, or damage is caused by a latent defect in A New Leaf TH or the negligence or willful misconduct of Client. Furthermore, you waive and release Client and its representatives from any legal claims, including, without limitation, any claims relating to copyright, rights of publicity or privacy, or moral rights, you may have in relation to the Materials referenced in Section 6.5, or Client' use and ownership of the Materials. You agree not to sue any of the A New Leaf on the basis of these waived and released claims.. You understand that A New Leaf would not permit you to participate in the Program without your agreeing to these waivers and releases.

9.4 Medical Care and Consent Waiver

If an emergency arises, you authorize A New Leaf staff to provide you or your child(ren) first aid and, through medical personnel of its choice, medical assistance, transportation, and emergency medical services. In addition, you give permission for A New Leaf to consent to such medical assistance for your child(ren) for any illness or injury that might occur. These consents do not impose a duty upon A New Leaf to provide such assistance, transportation, or services. In addition, you waive and release any claims against the A New Leaf staff arising out of any first aid, treatment, or medical service, including the lack or timing of such, made in connection with your family's presence at A New Leaf facilities or participation in the Program. You understand that A New Leaf will not be liable in case of illness or injury to your children. You also understand that A New Leaf's TH is not a health care provider or facility and that A New Leaf staff are not specially trained to treat or respond to medical emergencies.

10. General Provisions

10.1 Entire Agreement; Controlling Document

This Agreement, together with its exhibits and the Acceptance Letter, describes the entire agreement between you and A New Leaf, and supersedes any prior or contemporaneous written and oral agreements, negotiations, course of dealing, and communications between you and us relating to the Program. If there are inconsistencies between this Agreement and any forms A New Leaf uses in administering the Program, this Agreement will control.

10.2 Changes in this Document

This Agreement may be amended only as stated in a document signed by both you and us that states that it is an amendment to this Agreement. Discussions you may have with A New Leaf staff do not change this Agreement.

Program requirements and fees may change from time to time. New requirements and fees will take effect two weeks after A New Leaf announces the change, unless Client indicates otherwise.

You certify that you have read and understand the A New Leaf's Program Agreement and agree to abide by its terms. You agree that any violation of these terms will subject you (upon discretion of the Program Director) to expulsion from the Program and termination of residency at A New Leaf's TH Program. You asked a staff member for clarification of the portions of the agreement, if any, that you did not understand.

Name: _____
Program Director

Date: _____

PARTICIPANT

Signature: _____

Name: _____

Date: _____

PARTICIPANT

Signature: _____

Name: _____

Date: _____



Service Participation Agreement

ABC Continuum of Care
Permanent Supportive Housing Program

Participant Name:	
Behavioral Health Home (BHH) Agency:	
BHH Case Manager:	

Purpose

This Service Participation Agreement explains how we will work together while you are in the Permanent Supportive Housing program. The program provides services to help you find and keep housing, increase your income, and improve your health and well-being. This agreement follows HUD rules for the program. It explains what you agree to do and how the program will support you. Our goal is to help you stay safely housed, reach your goals, and build long-term stability.

Participant Responsibilities

You agree to engage with supportive services by doing the following:

1. Meet with your behavioral health case manager on a regular schedule.
2. Work with your BH case manager to work towards your goals identified on your individualized service plan (ISP), including:
 - Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc.)
 - Discuss strategies for achieving set goals and target dates for achievement
 - Follow up on referrals and attend appointments
 - Tell staff when you need help or your situation changes
3. To the best of your ability, you agree to take part in supportive services that you and your behavioral health case manager deem as necessary to help you remain successful in housing, including but not limited to:

ABC PSH Service Participation Agreement

- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)

You will not be required to participate in disability-related services unless the purpose of the program is to provide substance use treatment, as allowed under federal regulations.

Program Responsibilities: What the Program Agrees To Do

1. Coordinate with your Behavioral Health Case Manager for support services

ABC and HOM will coordinate with your behavioral health case manager to ensure your housing needs are met. ABC and HOM will:

- Include your case manager at intake meeting
- Provide access to Padmission (online apartment leads) to you and your case manager
- Communicate with case manager when you are experiencing tenancy issues so they can wrap around support and attend staffings to address issues
- Advocate with landlord for any tenancy issues to help maintain housing

2. Your behavioral health case manager will:

- Complete and monitor your service plan needs and goals
- Ensure your goals are member-driven and customized to meet your needs
- Provide referrals to community resources including but not limited to recovery supports/substance use treatment, vocational and employment providers, educational programs, SOAR specialist (for SSI/SSDI benefits), food assistance, transportation, life-skill training, peer support, community integration activities, and mainstream benefits

3. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

4. Respect Your Rights

The program will treat you with respect, keep your information private as required by law and provide a fair and accessible grievance and appeals process.

ABC PSH Service Participation Agreement

Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services, you may lose program assistance, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement does not replace your lease. Lease violations follow the legal process required by the landlord and local law.

Participant Rights

Throughout your participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services.
- Non-discrimination
- Ability to file grievances without retaliation

Termination and Appeals

Terminations follow HUD policies with written notice. You always have the right to appeal any termination decision.

Acknowledgment and Signatures

By signing below, you acknowledge that you have read, understood, and agree to comply with the terms of this Service Participation Agreement.

Participant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.



Service Participation Agreement

ABC Continuum of Care
Transitional Housing Program

Participant Name:	
Behavioral Health Home (BHH) Agency:	
BHH Case Manager:	

Purpose

This Service Participation Agreement explains how we will work together while you are in the Permanent Supportive Housing program. The program provides services to help you find and keep housing, increase your income, and improve your health and well-being. This agreement follows HUD rules for the program. It explains what you agree to do and how the program will support you. Our goal is to help you stay safely housed, reach your goals, and build long-term stability.

Participant Responsibilities

You agree to engage with supportive services by doing the following:

1. Meet with your behavioral health case manager on a regular schedule.
2. Work with your BH case manager to work towards your goals identified on your individualized service plan (ISP), including:
 - Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc.)
 - Discuss strategies for achieving set goals and target dates for achievement
 - Follow up on referrals and attend appointments
 - Tell staff when you need help or your situation changes
3. Follow a weekly schedule reflecting up to 20 hours of supportive services (or prorated hours if you are employed) that you and your behavioral health case manager deem as necessary to help you remain successful in housing, including but not limited to:

ABC PSH Service Participation Agreement

- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)

You will not be required to participate in disability-related services unless the purpose of the program is to provide substance use treatment, as allowed under federal regulations.

Program Responsibilities: What the Program Agrees To Do

1. Coordinate with your Behavioral Health Case Manager for support services

ABC and HOM will coordinate with your behavioral health case manager to ensure your housing needs are met. ABC and HOM will:

- Include your case manager at intake meeting
- Provide access to Padmission (online apartment leads) to you and your case manager
- Communicate with case manager when you are experiencing tenancy issues so they can wrap around support and attend staffings to address issues
- Advocate with landlord for any tenancy issues to help maintain housing

2. Your behavioral health case manager will:

- Complete and monitor your service plan needs and goals
- Ensure your goals are member-driven and customized to meet your needs
- Provide referrals to community resources including but not limited to recovery supports/substance use treatment, vocational and employment providers, educational programs, SOAR specialist (for SSI/SSDI benefits), food assistance, transportation, life-skill training, peer support, community integration activities, and mainstream benefits

3. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

4. Respect Your Rights

The program will treat you with respect, keep your information private as required by law and provide a fair and accessible grievance and appeals process.

ABC PSH Service Participation Agreement

Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services, you may lose program assistance, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement does not replace your lease. Lease violations follow the legal process required by the landlord and local law.

Participant Rights

Throughout your participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services.
- Non-discrimination
- Ability to file grievances without retaliation
- Request an exemption from or proration of service participation requirements if you are employed, over the age of 62 and/or have a qualifying disability.

Termination and Appeals

Terminations follow HUD policies with written notice. You always have the right to appeal any termination decision.

Acknowledgment and Signatures

By signing below, you acknowledge that you have read, understood, and agree to comply with the terms of this Service Participation Agreement.

Participant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.



CBI Rio Fresco Transitional Housing Program Participant Agreement

HUD CoC–Funded Transitional Housing

This Participant Agreement describes the expectations, responsibilities, and rights of individuals enrolled in the **CBI Rio Fresco Transitional Housing Program**. This site-based program provides time-limited housing paired with structured services focused on behavioral health recovery, including mental health services, substance use treatment and recovery services, and support for co-occurring disorders, while promoting , independent living skills, stabilization, and transition to permanent housing.

The program is designed to serve individuals experiencing homelessness who have behavioral health needs, including mental health disorders, substance use disorders, or co-occurring mental health and substance use disorders, and who would benefit from structured transitional housing and supportive services.

1. Participation in services is required to maintain eligibility for the program-funded subsidy. Loss of subsidy does not automatically result in loss of housing.

Program Overview

The Site-Based Transitional Housing program provides:

- Safe and stable site-based housing
- A structured, recovery-focused service model
- Behavioral health treatment and recovery services, case management, skill-building, and supportive supports
- Assistance with transitioning to permanent housing

Participants reside in a designated site-based unit linked to the TH program.

2. Participant Rights

Participants have the right to:

- Be treated with dignity, respect, and cultural consideration
- Receive housing without discrimination or retaliation
- Decline any specific service at any time while remaining informed about subsidy eligibility



- Not be terminated from housing tenancy for failing to participate in services
- File grievances without fear of negative consequences and receive timely responses
- Confidential, HIPAA-compliant protection of personal information
- Participate in developing their own individualized service plan

2.1 VAWA 2022 Protections:

Participants are protected from denial of assistance, subsidy loss, or termination of housing due to being a victim of domestic violence, dating violence, sexual assault, or stalking. Participants may request emergency transfers and may self-certify incidents of violence. All VAWA-related information is kept strictly confidential.

2.2 Reasonable Accommodations (Section 504/ADA):

Participants may request reasonable accommodations at any time for disability-related needs, including adjustments to service expectations, appointment types, communication methods, or program requirements.

2.3 Termination and Due Process (24 CFR 578.91):

Participants will not be terminated from the program except for serious or repeated violations of program requirements. Before any termination of assistance:

- The program will attempt problem-solving and additional engagement.
- Written notice of the reason for termination will be provided.
- The participant will have the opportunity to appeal and present objections.
- A written final decision will be issued.

Termination from assistance does not necessarily result in the loss of tenancy.

3. Participation Expectations

Participation in services is a requirement for the **program-funded transitional housing subsidy**.

3.1 Required Service Participation

Participants agree to engage in 20 hours per week of individualized recovery and support services, including but not limited to:

Behavioral Health and Recovery Services

- Individual, family, or group counseling
- Outpatient or Intensive Outpatient (IOP) sessions
- Psychiatric evaluation and medication management, as appropriate



- Substance use treatment services, when clinically indicated
- Medication-assisted treatment (as applicable)
- Relapse prevention services
- Recovery-oriented classes or groups
- Mental health skill-building and symptom management

Supportive Services

- Case management and care coordination
- Skills development and psychoeducation
- Peer support services
- Health and wellness activities
- Employment readiness, job search or job retention support
- Education support (high school, GED, college, vocational training)
- Recovery-oriented group sessions
- Life skills development (budgeting, cooking, cleaning, transportation, communication, etc.)
- Housing transition planning
- Safety planning, independent living skills, or community-based engagement

Hours may be completed through in-person sessions, on-site services, community-based activities, or telehealth.

3.2 Participation Standards

Participants agree to:

- Attend scheduled treatment sessions and program activities
- Communicate with staff if unable to attend
- Participate in updates to the individualized service and recovery plan
- Inform staff of any safety concerns, significant changes in behavioral health needs, relapse events, or other service needs

4. Housing Responsibilities

Because this is a site-based program, participants reside in units directly tied to the TH program.

Participants agree to:

- Follow the terms of the occupancy or participation agreement
- Respect other residents, staff, and property



- Maintain the unit in a safe and sanitary condition
- Follow facility safety and community guidelines
- Report maintenance, safety, or environmental concerns

5. Program Responsibilities

The program agrees to:

- Provide safe, supportive housing within the site-based facility
- Offer a full continuum of supportive services and behavioral health services
- Support your behavioral health, recovery, and housing goals through person-centered, individualized service planning
- Assist you in transitioning to permanent housing
- Provide written notice of any changes to subsidy status
- Provide reasonable accommodations where appropriate

6. Subsidy Eligibility

The housing subsidy associated with the site-based unit is tied to service participation.

6.1 Conditions for Maintaining Subsidy

Participants must:

- Engage in individualized behavioral health, recovery and supportive services identified in the participant's service plan
- Complete at least 20 hours/week of individualized services
- Maintain regular communication with assigned program staff

6.2 Non-Participation

If a participant does not meet service expectations:

1. Staff will attempt additional engagement
2. Barriers will be identified and additional supports offered
3. A revised service/recovery plan may be developed
4. Continued non-participation may result in loss of the subsidy

Loss of subsidy does not automatically result in loss of the housing unit.

If subsidy eligibility changes, the program will assist the participant in exploring alternatives or next steps.

7. Length of Stay



Site-Based Transitional Housing is time-limited, not to exceed **24 months**, in accordance with HUD regulations. Length of stay is individualized and dependent on:

- Progress toward behavioral health and housing stabilization goals
- Engagement in services
- Readiness for permanent housing

8. Grievance Process

Participants may submit grievances regarding program decisions, services, or staff interactions. A written grievance procedure is provided during intake.

9. Participant Acknowledgment

By signing below, you acknowledge that:

- You understand the program's service participation expectations
- You understand the difference between **housing** and **subsidy eligibility**
- You agree to work collaboratively with program staff toward behavioral health, recovery and housing goals
- You have had the opportunity to ask questions

Participant Name: _____

Participant Signature: _____

Date: _____

Program Staff Name: _____

Program Staff Signature: _____

Date: _____



CBI MAG Scattered-Site Transitional Housing Participant Agreement

HUD CoC–Funded Transitional Housing

This Participant Agreement outlines the expectations, responsibilities, and rights of individuals enrolled in the **CBI MAG scattered-site Transitional Housing (TH) Program** supported by the HUD Continuum of Care Program (24 CFR Part 578).

This program provides time-limited rental assistance paired with individualized services focused on behavioral health, including mental health services, substance use treatment and recovery services, and support for individuals experiencing co-occurring disorders, while promoting, stability, independence, and transition to permanent housing.

The program is designed to serve individuals experiencing homelessness who have behavioral health needs, including mental health disorders, substance use disorders, or co-occurring mental health and substance use disorders, and who would benefit from structured transitional housing and supportive services.

Participation in services is voluntary in the housing sense. You will not lose your housing for declining services. However, continued receipt of the program-funded subsidy requires active participation in services as defined in this Agreement.

1. Program Overview

The scattered-site Transitional Housing Program provides time-limited, housing paired with individualized behavioral health and supportive services. The goal is to support stabilization, recovery, development of independent living skills and successful transition to permanent housing.

Services may include:

- Mental health treatment and recovery services
- Substance use treatment and recovery services
- Support for individuals with co-occurring disorders
- Case management and care coordination
- Life skills development
- Employment and education supports



- Housing stabilization and transition planning

2. Participant Rights

Participants have the right to:

- Be treated with dignity and respect
- Receive housing without discrimination or retaliation
- Decline any specific service at any time while remaining informed about subsidy eligibility
- Not be terminated from housing tenancy for failing to participate in services
- File grievances without fear of negative consequences and receive timely responses
- Confidential, HIPAA-compliant protection of personal information
- Participate in developing their own individualized service plan

2.1 VAWA 2022 Protections:

Participants are protected from denial of assistance, subsidy loss, or termination of housing due to being a victim of domestic violence, dating violence, sexual assault, or stalking. Participants may request emergency transfers and may self-certify incidents of violence. All VAWA-related information is kept strictly confidential.

2.2 Reasonable Accommodations (Section 504/ADA):

Participants may request reasonable accommodations at any time for disability-related needs, including adjustments to service expectations, appointment types, communication methods, or program requirements.

2.3 Termination and Due Process (24 CFR 578.91):

Participants will not be terminated from the program except for serious or repeated violations of program requirements. Before any termination of assistance:

- The program will attempt problem-solving and additional engagement.
- Written notice of the reason for termination will be provided.
- The participant will have the opportunity to appeal and present objections.
- A written final decision will be issued.

Termination from assistance does not necessarily result in the loss of tenancy.

3. Participant Responsibilities

As a participant in this program, you agree to:



3.1 Participation in Services (Required for Subsidy Eligibility)

To continue receiving the transitional housing **subsidy**, participants must participate in **20 hours/week of individualized services**, which may include:

Behavioral Health and Recovery Services:

- Individual, family, or group counseling
- Outpatient or Intensive Outpatient (IOP) treatment services
- Psychiatric evaluation and medication management, as appropriate
- Substance use treatment services, when clinically indicated
- Medication-assisted treatment (as applicable)
- Recovery-oriented classes or groups
- Mental health skill-building and symptom management

Supportive Services:

- Case management and care coordination
- Skills development and psychoeducation
- Peer support services
- Health and wellness activities
- Employment readiness, job search or job retention support
- Education support (high school, GED, college, vocational training)
- Recovery-oriented group sessions
- Life skills development (budgeting, cooking, cleaning, transportation, communication, etc.)
- Housing transition planning
- Safety planning, independent living skills, or community-based engagement

These hours are individualized and may be a combination of direct services, groups, home-based sessions, telehealth, and community-based supports.

3.2 Engagement

You agree to:

- Attend scheduled appointments
- Communicate with your provider if you cannot attend
- Participate in creating and updating your individualized service and housing stabilization plan
- Work collaboratively with assigned staff



3.3 Housing Responsibilities

Because this is a **scattered-site model**, participants live in independent units leased in the community. Participants agree to:

- Follow the terms of your lease or occupancy agreement
- Maintain your unit in a safe and sanitary condition
- Respect neighbors, property managers, and community rules
- Respect the rights and safety of staff
- Follow all community safety guidelines
- Report maintenance or safety concerns in a timely manner
- Allow required home visits
- Notify staff of rent issues, notices, or landlord communication

4. Program Responsibilities

The program is responsible for:

- Provide rental assistance and housing supports in compliance with HUD regulations
- Offering a full continuum of supportive services, behavioral health services, and recovery supports
- Supporting your behavioral health, recovery, and housing goals through person-centered, individualized service planning
- Assisting you in transitioning to permanent housing
- Provide written notice of any changes to subsidy status
- Provide reasonable accommodations where appropriate
- Ensuring participation requirements do not jeopardize your tenancy

5. Housing vs. Subsidy Clarification

HUD requires that **tenancy is not conditioned on service participation**.

- You will not lose your housing for declining or missing services.
- You may lose your program-funded subsidy for not engaging in required services.
- If you lose your subsidy due to non-participation, the program will help you explore other housing options, benefits, and resources.

Loss of subsidy does not mean eviction from your unit, but it may affect your financial responsibility or eligibility for ongoing program services.

6. Program Duration



Transitional Housing is designed to be time-limited (up to 24 months per HUD regulations). Length of stay is individualized and based on:

- Progress toward behavioral health and housing stabilization goals
- Readiness for permanent housing
- Participant choice and goals

7. Non-Compliance With Service Expectations

If you are not meeting the required level of service participation:

1. Staff will attempt outreach and engagement
2. A case review will occur to identify barriers and strengthen supports
3. You will be offered a revised service plan
4. If non-participation continues, you may be exited from the subsidy component of the program

You will receive written notice and assistance exploring alternative housing or payment options if subsidy loss occurs.

8. Grievance Procedure

If you disagree with decisions related to services, subsidy, or participation requirements, you may file a grievance without fear of retaliation. A written grievance procedure is provided during intake.

9. VAWA Protections

You are protected from losing housing or subsidy due to being a victim of domestic violence, dating violence, sexual assault, or stalking. You may request emergency transfer and may self-certify.

10. Participant Acknowledgment

By signing below, you acknowledge that:

- You understand the program's service participation expectations
- You understand the difference between **housing** and **subsidy eligibility**
- You understand the relationship between service participation and subsidy eligibility
- You have had the opportunity to ask questions



Participant Name: _____

Participant Signature: _____

Date: _____

Program Staff Name: _____

Program Staff Signature: _____

Date: _____



Service Participation Agreement _Projects with SUD Purpose Template

Project Name: Transitional Pathways of Success Participant Name: _____

Unit/Room: _____

Effective Date: _____

1. Purpose

This Service Participation Agreement applies to projects whose purpose is to provide Substance Use Disorder (SUD) treatment services. Your participation in SUD-related services is required under the Housing and Urban Development 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals. Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Client Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Work on your goals
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your case manager will also help with referrals, benefits, employment services, and other supports that fit your needs.

B. Work on Your Housing Stability Plan

You and your case manager will create a Housing Stability Plan. You agree to:

- Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc)
- Discuss strategies for achieving set goals and target dates for achievement
- Discuss the services available to you, when and how often they are provided and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- Follow a weekly schedule reflecting up to 20 hours of options (or prorated hours if you are employed)



- Follow up on referrals and attend appointments
- Engage in housing retention activities, if necessary
- Turn in paperwork needed for recertification or income updates and
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that the program identifies as necessary to help you remain successful in housing, for at least 20h/week, including but not limited to:

- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals

D. Participate in SUD Treatment

Part of your program participation you agree to take part in:

- Scheduled individual or group counseling or treatment sessions
- Recovery-focused case management
- Required assessments and plan updates and
- Safety and sobriety expectations in shared spaces

Your level of participation will match your stage of change and your treatment plan. Staff will work with you in a supportive, person-centered way.

D. Participate in On-Site SUD Treatment Services (if applicable)

If this program provides on-site SUD treatment and you have a SUD, you may be required to take part in treatment per local CoC policies and federal regulations.

What “On-Site Substance Use Treatment” Means: SUD treatment and recovery services are provided at the project location, at a co-located service office, in a private meeting space within the building, or through telehealth or other virtual service modalities that the participant can access from their unit, a private project-supported space, or another appropriate location connected to the project, by qualified staff or through a formal partnership with a licensed SUD provider. These services may include one or more of the following:

- Case management focused on SUD treatment and recovery needs
- Clinical assessment and treatment planning for SUD
- Peer recovery support services
- Individual or group counseling using evidence-based approaches
- Medication-Assisted Treatment (MAT) or medication management
- Relapse prevention, psychoeducation, and structured recovery groups and
- Warm handoffs to higher levels of care when needed



3. Program Responsibilities: What the Program Agrees To Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a case manager
- Help you understand your lease, if applicable
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need.
- Provide 20 hours per week of customized supportive services
- Services may include project-based, partner-delivered, or participant self-directed activities, and will be delivered on-site, off-site, or virtually
- Tailor services for you based on your need
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project or partner provided services, supports, and activities selected in collaboration with each participant, based on their goals, strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Health & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment, financial or other counseling, or income-support navigation
- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and



- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services, **you may lose program assistance**, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services, unless the purpose of the program is to provide SUD treatment services.
- Non-discrimination
- Ability to file grievances without retaliation
- Request an exemption from or proration of service participation requirements if you are employed, over the age of 62 and/or have a qualifying disability under 24 CFR 8.3 or developmental disability under 24 CFR 578.3

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the responsibilities of the program and that I may ask questions at any time.

Signatures:

Participant: _____

Date: _____

Staff: _____

Date: _____



*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.



On-Site Substance Use Treatment

Definition

On-site substance use treatment refers to the delivery of clinically appropriate Substance Use Disorder (SUD) treatment and recovery services at a project location by qualified behavioral health professionals or certified peer recovery staff, or through a formal partnership with a licensed SUD treatment provider that provides services at the project site on a scheduled and consistent basis. These services must align with SAMHSA-recognized evidence-based practices and state licensure requirements and must support participant engagement across the stages of change.

Core Components

A project may be considered to provide on-site substance use treatment if it offers, at minimum, **one or more** of the following services at the project location:

- **Case management** or service coordination specifically addressing SUD treatment and recovery needs
- **Clinical assessment and treatment planning** for SUD
- **Individual and/or group counseling** using evidence-based modalities (e.g., CBT, MI, CM)
- **Peer recovery support services** delivered by certified peer supporters
- **Medication-Assisted Treatment (MAT)** or medication management delivered:
 - directly by licensed medical staff on-site, **or**
 - via telehealth with clinical staff providing on-site support
- **Relapse prevention**, psychoeducation, and structured recovery groups
- **Facilitated referral and warm handoff** to higher levels of care (IOP, detox, inpatient, residential)

Acceptable Delivery Models

The following are considered *on-site* when documented:

- Services provided at the property on a regular schedule by licensed clinicians or certified peers who are employed by the project or a partner provider
- Telehealth sessions conducted at the project site with clinical facilitation
- A combination of on-site direct services and scheduled on-site availability from a partner agency

Minimum Expectations for Documentation

Projects claiming on-site SUD treatment must maintain:

1. A written description of services delivered at the site
2. Licensure or certification documentation of the treating agency or staff, consistent with state requirements
3. A schedule or service plan showing regular on-site availability
4. A formal partnership agreement or MOU (if using partner providers)
5. A **Service Participation Agreement** that complies with 24 CFR 578.75(h) and CoC Program funding requirements.





Pathways of Hope Service Participation Agreement

This Service Participation Agreement outlines the supportive service expectations for participants residing in the project. These services are designed to help participants obtain and maintain housing stability, increase income, improve health and well-being, and successfully exit to permanent housing.

1. I will ensure that my behavior is always safe and promotes the safety of myself and others by treating staff members, other participants, service/assistance animals, and guests with dignity and respect. I understand that verbal and physical abuse/violence, threats, or inappropriate behavior will not be tolerated and will result in possible immediate dismissal from the program.
2. I understand that Pathways of Hope has a zero-tolerance policy for firearms on the property. Any guns on the property will result in an immediate dismissal from the program. I will not possess any dangerous items that may be perceived as a weapon at the shelter (Ex: BB guns, Pepper Spray, Knives, Screwdrivers, and anything sharp) and can result in an immediate dismissal from the program.
3. I understand that Pathways of Hope has a zero-tolerance policy for using, possessing or selling of drugs on property. Any use of drugs on the property or found drug paraphernalia with the smell of drugs in the room or suspicion of use on the property will result in an immediate dismissal from the program.
4. I understand I will not consume alcohol or have alcohol products on the Pathways of Hope property.
5. I will allow Pathways of Hope staff members to enter my assigned cubicle at any time without advanced notice, including if they believe my safety or the safety of others is in question. This includes completing cubicle and belongings checks or searches, wellness checks, and maintenance checks for repairs.
6. I will utilize the bed assigned to me nightly. I understand that my Housing Care

Navigator must approve all absences. Unexcused absences may result in an exit from the program. Three consecutive unexcused absences may result in a dismissal from the program. I will not have any guests enter the shelter or living quarters.

7. I understand the program's expectations to participate in supportive services for at least 20 hours per week.

8. I understand that I will participate in rehabilitation and recovery activities as required by my clinical team and housing team which is included in the 20 hours weekly.

9. I understand that the program expectations listed above are an agreement that is required to continue to stay in the program.

10. I understand that I can access services provided in a trauma-informed manner. I can accept or decline disability-related services and may request reasonable accommodation.

11. I understand that I am expected to pay 30% of my income towards program fees by the 1st of every month.

I have read and agree to abide by all the rules outlined in this document and understand that I am responsible for knowing the rules and will be held accountable for not abiding them.

Housing Care Navigator: _____

Participant Name: _____

Date Completed: _____

RIGHTS AND RESPONSIBILITIES

The following rights and responsibilities are to set out expectations and rules to help keep harmony in our program where multiple individuals live together and share common spaces.

You have the right to be respected.

You have the right to be treated with respect and without discrimination by any participant or staff.

You have the right to be heard.

We encourage participants to deal with conflicts directly with the people involved using their communication skills. Staff are available to facilitate mediation and the grievance process.

You have the right to live without the threat of violence.

1. Physical or verbal violence, threats, and sexual harassment are not acceptable.
2. No weapons are allowed in the building.
3. Any illegal activity on the property could jeopardize your continued stay.

You have the right to a healthy, sober, and drug-free environment.

1. Alcohol, marijuana, and illegal drugs are not permitted on the premises.
2. Staff will support participants in recovery.
3. Participants displaying disruptive behaviors due to intoxication may be asked to leave for the night and meet with their navigator.

You have the right to a clean and physically safe environment.

1. Maintain bed areas, restrooms, and common areas.
2. Clean up after yourself and complete assigned chores.
3. Smoking is not allowed inside.
4. Medications and valuables must be stored in your locked footlocker.
5. Animal owners must clean up after their animals.

You have the right to reside in a program that works for you and to make your own choices.

1. Your navigator can help find an alternative shelter if needed.
2. If you stay away more than 72 hours, belongings may be packed.
3. The beginning will be held for one week.
4. You are expected to meet with your navigator two times weekly and complete 20 hours of weekly supportive services either in groups or with your health home / combination.
5. Attend weekly community meetings.

Those disrupting the serenity of our environment may lose the privilege of being welcomed at Pathways of Hope.

Immediate dismissal may occur for:

1. Violence or threats of violence.
2. Bringing weapons, alcohol, or illegal drugs into the shelter.
3. Property destruction or theft.

If you are having trouble with any other responsibilities related to the program, staff will work with you to create an intent to support addressing those issues and supporting you. If you are unable to follow the intent to support, you may be placed on a program pause or if continued dismissed from the program.

House care navigator: _____

Participant name: _____

Date Completed: _____

MERCYHOUSE

Guest Expectations

Welcome to our transitional shelter program. We hope your stay with us allows you to begin your path to ending your homelessness. To ensure that all guests are able to comfortably work toward that goal, the following expectations need to be followed while on the transitional shelter property, on any program transportation, as well as the immediate vicinity of the transitional shelter or drop-off location.

All guests are asked to read and initial each of the following sections as an acknowledgement that they understand what is expected of them while enrolled in the program:

1. Demonstrate responsibility for yourself, your actions, and your housing plan. _____
2. Guests are expected to actively work their housing plan. By signing these expectations, you understand that you are not guaranteed housing by enrolling in this program, and that your continued enrollment is contingent on the work you complete with your Housing Navigator. The goal is to get you connected to housing resources as quickly as possible. You will be expected to meet regularly with your Housing Navigator at scheduled times to discuss your housing plans. Part of your Housing Plan will be for you to identify tasks that you need to complete in order to achieve your goal of securing housing. Your progress toward this goal will be reviewed at 30-day increments, with formal extension requests required after 6 months. _____
3. **Guests agree to actively participate in up to 20 hours per week of case management and supportive services as a condition of occupancy. Participation includes arriving on time for scheduled sessions, engaging meaningfully in discussions, and completing agreed-upon action steps. This 20-hour expectation may be proportionately reduced for Guests who are employed. It does not apply to Guests age 62 or older, or to those with a physical or developmental disability as defined under 24 CFR 582.5 (excluding substance use disorder). Failure to attend or meaningfully participate in supportive services constitutes a breach of these expectations. In cases of non-participation, Mercy House will issue a written notice identifying the missed or incomplete obligations and will provide the Guest an opportunity to remedy the breach by re-engaging in services. If the Guest fails to comply with supportive service participation requirements for three (3) consecutive scheduled sessions, or repeatedly fails to participate over a 30-day period despite written notice and an opportunity to correct the issue, the Guest will be terminated from the transitional housing program in accordance with program policy.** _____
3. While residing in the program, Guests are expected to actively seek opportunities to increase their income, but not limited to securing earned income through employment, participating in workforce development or training programs, applying for eligible benefits, or pursuing other lawful income-enhancing opportunities identified in collaboration with their Housing Navigator. _____

4. While participating in the program, Guests are expected to proactively address barriers to stable housing — including, when applicable, substance use. If a Guest identifies substance use as a barrier, they are required to make reasonable efforts to engage with both on-site and off-site individual and group SUD services, and to collaborate with their Housing Navigator to define the most beneficial path forward which may include but is not limited to; attending scheduled clinical assessments, participating in the development and periodic updating of a personalized treatment plan, engaging actively in recovery support services, utilizing resources provided by the program to support long-term stability and well-being, follow through on referrals made for appropriate levels of care — whether that means intensive outpatient treatment, community support groups, or other recommended services — as determined in consultation with their Housing Navigator and health care team.____
5. Follow all health and safety policies. These policies include, but are not limited to:
- Every guest agrees to utilize the room provided to them for their approved household only, and will not allow others to stay in it. Households are defined at the time of intake, and no one may be added to a household without the explicit permission from management. _____
 - No room-to-room visits will be permitted. Non-program visitors are also prohibited. _____
 - Guests are expected to maintain their hygiene (including changing into clean clothes when possible), laundry once a week and showering at least twice a week. _____
 - Due to COVID-19, all guests are expected to wear masks if observed having any symptoms of illness, and must agree to temperature checks if asked. Social distancing protocols may also be enforced that all guests must follow. _____
 - No additional furniture will be permitted in the rooms. This includes the addition of shelves, tables, chairs, cabinets, etc. _____
 - Guests are expected to maintain the safety of their rooms by straightening their beds when not present in the room. The amount of belongings a guest may have in their rooms is limited to no more than: 2 indoor bins (or equivalent space, supplied by program) and 2 personal bags (no larger than a backpack or suitcase). Belongings should be kept either in these containers or on the supplied nightstands. No items will be permitted to be kept on the bare floor, other than these containers, a bicycle, and 2 pairs of shoes. _____
 - Guests will keep their units safe and clean; maintaining good housekeeping, disposing of garbage and waste properly, and storing food properly and securely, so as to not attract pests. Guests will be assigned two cleaning days every week. On these days, the guest will be expected to have all trash in a trash can, toilets flushed and items off the floor so staff can enter to sweep, mop and scrub. _____

- No smoking is allowed in the room at any time. _____
 - Smoke and carbon monoxide detectors are installed in every unit for your protection. These are not to be removed or tampered with, and doing so may result in an immediate exit. Detectors will be checked weekly by staff during housekeeping visits. If you have any problems with your detectors, please notify staff immediately. **In the event of a fire, contact 911 immediately. Onsite staff and security are available 24 hours a day, 7 days a week and can also be informed to contact 911 on your behalf.** _____
 - All prescription medication must be recorded with Staff at Intake and stored in your room in its original labeled container. Pills or medication NOT matching the original labeled container may be confiscated. No recreational marijuana will be allowed on-site. Medical marijuana may be kept in your room with a valid Medicinal Use Card and must be 1 oz. or less. _____
 - Trash and recycling may not be brought onto the property. _____
 - In the event of a plumbing (including water leak or overflow), electrical, or pest issue, guests should notify staff *immediately* to ensure the matters are attended to as quickly as possible. Guests will be provided with a plunger and instructed on its use, as well as how to turn off the water at the base of the toilet in case of an emergency. _____
6. Staff will need to enter each room several times a day. Guests will not need to be present for this, but staff will knock on the door three times in an attempt for the guest to open the door for them. After the third attempt, staff will unlock the door and enter. Examples of when staff will need to enter the room include:
- Every morning and evening, as part of a daily wellness check schedule _____
 - On each guest's assigned laundry day, to pick up/drop off laundry and linens _____
 - Twice a week on each guest's assigned room cleaning days _____
 - In the event of any emergency or safety concern _____

- For pest control or maintenance issues (which may include outside vendors) _____
7. For your comfort and safety, all guests are expected to abstain from behavior that is disruptive and unacceptable to others. Examples include verbal harassment, physical harassment, excessive profanity, possessing weapons (or items that may be perceived as weapons) or contraband, drug dealing, drug/alcohol use, theft, etc. Additional examples of items considered contraband can be made available upon request. Serious offenses include but are not limited to: possession of weapons or hard narcotics, use of racial slurs, sexual harassment including nudity or obscene/sexual behavior, setting fires, threats or violent behavior, and any other inappropriate physical contact. Serious violations may result in an immediate exit from the transitional shelter. If you are asked to leave, you must leave without incident in order to be eligible for a return to the program in the future. If a driver is available, you may be transported to an approved drop off location if it is deemed by management as safe to do so. _____
 8. If a guest's behavior is extremely disruptive and staff or security asks you to step outside or remove yourself from an area so you may calm down, you are expected to comply with this request. This is for your benefit, and you may be able to rejoin the group when your behavior is no longer a disruption to the other transitional shelter guests. _
 9. Staff reserves the right to call 911 for any emergency. Should a guest feel the need to call police, 911, or an ambulance, they agree to notify staff immediately so they can ensure easy access for first responders and provide initial support where necessary. Dialing 911 from an in-room phone will ring the front office, who can call police or paramedics as needed. _____
 10. Guests are expected to return each night before the posted curfew unless allowed special consideration by management (e.g.: late entry to accommodate work, school, disability-related considerations, or other reasonably extenuating circumstances). Guests are not allowed to miss two consecutive nights or 3 nights in any calendar month without clearing the absence with their Housing Navigator. Guests are expected to sign-in daily and may not sign or hold beds for others. The program manager may grant excused nights out of the transitional shelter upon request if deemed necessary and appropriate.

 11. This site utilizes a keyed/keycard entry system for all guests' rooms. Guests may not loan their assigned keys or keycards to any person at any time. For the safety of all guests and staff, guests are asked to notify staff immediately if their key/keycard is lost or stolen. Guests are responsible for the safekeeping of their assigned keys/keycards, and excessive key loss may result in the need to complete an action plan. _____
 12. Photo ID's are required of all registered guests for safety purposes. If you do not have a State ID the Mercy House Staff will assist you in acquiring an ID within the first few days after enrollment. Mercy House may take photos and thumbprints to produce program ID's for guests if necessary. By entering this program, you give your consent to this. A photo ID of some sort is also required to receive a bath towel and is also used when

waiting in the dinner line (a loaner ID may be created for you in the interim if you do not yet have one). _____

13. Out of respect for, and to protect the privacy of our staff and guests, no audio/video-recording or taking of photos is permitted on premises, except by the expressed permission from Management. _____
14. For your safety, this site may incorporate closed-circuit surveillance cameras as part of its security system. There are no cameras installed in any guest rooms. Any footage captured is used only for safety and security purposes and may be shared with law enforcement as part of an active investigation. No footage will be shared with the general public. _____
15. The pool area is gated and locked and is NOT available for use by guests or visitors. _____
16. Smoking and vaping are permitted in the designated outdoor smoking area only. No drug or alcohol use, paraphernalia, or marijuana use will be permitted in or around the transitional shelter. Anything containing THC (with or without a prescription) will not be allowed. Children are not permitted in the smoking area. _
17. Guests are expected to attend resident meetings and contribute to the community. This includes mandatory participation in all fire and safety drills. _____
18. All guests are expected to be Good Neighbors of the community in which they are served and have an obligation to comply with all state and local laws and ordinances and behave in a courteous manner at all times, including while traveling to and from the property. Complaints from residents, business owners, or public officials may result in expulsion from Mercy House Programs. _____
19. Guest vehicles may be parked on transitional shelter property at the owner's risk and liability, in designated areas, once the vehicle is registered with the program. A valid license, registration, and insurance are required in the name of the guest. RVs (Recreational Vehicles) are not permitted on-site. Guests are only allowed one bike per person, and are not allowed to store spare bike parts. All vehicles, including bicycles, must be operable. Abandoned or inoperable vehicles will be subject to tow at the owner's expense. __
20. Several areas on site are restricted to staff and security only. If signage is posted designating an area as "Staff Only" or "No Trespassing", guests are expected to respect the boundary. _____
21. Please respect the privacy of others. Children must be attended to by an adult family member at all times. Guests are not allowed to enter any sleeping area other than the one they were assigned. _____
22. Guests are expected to respect the rest and sleep of their neighbors. The site enjoys designated "quiet hours" between 10:00 pm until 7:00 am. During this time, indoor

voices should be used so as to not disturb anyone's rest. Likewise, guests are not allowed to play loud music or watch videos with loud audio after 10:00 pm. _____

23. Although we respect everyone's right to privacy, we reserve the right to pat down and search all persons as a precaution against any potential security risks. Guests will be informed of items not allowed at the transitional shelter. If those items are found on site they may be confiscated and destroyed. ____
24. Approved pets, Service Animals and ESAs must be registered and cleared ahead of time with program management. Clients are limited to no-more-than one animal (with the possible exception of service animals), and the animal must be present with the client at the time of intake. All pet owners must agree to and follow the guidelines provided in the Animal Expectations, which is a separate document that will be given upon entry of the animal into the transitional shelter. ____
25. Neither Mercy House nor any of its vendors are in any way responsible or liable for lost, stolen, or damaged items that guests bring onto the premises. Guests are encouraged to keep valuable items close and guarded and are asked to turn in any found items to the front desk. We recommend that those who use the supplied charging stations have their electronics clearly marked or customized for easy identification. _____
26. Cash is never to be given to Staff, Volunteers, or Interns at ANY time. _____
27. It is our desire to never deny transitional shelter or services to our guests, however, in the case that behavior becomes a health or safety risk, Transitional shelter Management can expel or prevent any guests from staying at the transitional shelter. Any conflicts between guests should be brought to the attention of the staff immediately. ____
28. At the time of your exit from the program, all transitional shelter property (such as bedding, towels, pillows, laundry bags, etc.) must be returned. ____
29. Any guests who exit will have 7 days (one week) to pick up any items left on-site before they are discarded. Guests must call and speak to a site leader or program manager to schedule a pickup. _____
30. We wish to keep open communication between Mercy House and our guests. Each transitional shelter has a grievance binder at the front office which contains our Grievance Policies and forms. We ask that any issues be brought to our attention first through informal processes, so that we can address them quickly as they occur. For this reason every site also has a suggestions box for you to leave comments or complaints. If any part of the program, staff or services is lacking, please do not hesitate to notify management immediately by speaking to the on-duty site leader or manager. If appropriate, you may also choose to complete a "Request for Consideration" form, to describe issues that you would like to see resolved. If after speaking to staff and completing a "Request for Consideration" form, you feel the matter has not been resolved, you will find a copy of the formal Grievance Form in this binder. _____

31. Any guest that does not follow these expectations is jeopardizing their ability to accomplish their housing plan and may be exited from the transitional shelter. Because everyone can make a mistake, when an expectation is not met the staff will clarify any misunderstanding of the expectation and discuss ways that each guest can avoid further violations. If the violations continue, staff will meet with the guest to create an action plan in support of the client getting back on-track with their housing goals and meeting the program expectations. Guests who have five action plans and continue to violate these expectations will be exited from the transitional shelter. Likewise, if a guest receives three action plans for the same violation and continues the same behavior, they may be exited from the program as well. ____

32. During the school year, school-aged children must be enrolled in classes within 14 days of their date of intake, and families with children who are not enrolled will be connected to a school district representative to facilitate their enrollment. _____

As a result of initialing these expectations and signing this form, I understand that expectations, health, and safety policies may change as necessary and that I will be informed of these changes, and I am required to abide by any amended policies.

I have read the above and agree to follow the Transitional shelter Expectations as a condition of my participation of the program.

Name (please print): _____

Signature: _____ Date: _____



Native
American
Connections

Administration Office

3216 N. 3rd St. Phoenix, AZ 85012

www.nativeconnections.org

602-254-3247

Service Participation Agreement Permanent Supportive Housing

Project Name: _____ Resident Name: _____

Unit: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement outlines the supportive service expectations for participants residing in the project. These services are designed to help you obtain and maintain housing stability, increase income, improve health and well-being, and successfully exit to permanent housing. This agreement complies with Housing and Urban Development (HUD) 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded.

The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals.

Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Participant Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Work on your goals
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your Case Manager will also help with referrals, benefits, employment services, and other support that fit your needs.

B. Work on Your Housing Stability Plan

You and your Case Manager will create a Housing Stability Plan. You agree to:

- Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc.)
- Discuss the services and resources available to you, and select the service types you are interested in
- Follow up on referrals and attend appointments
- Engage in monthly home visits or other housing retention activities, if necessary
- Turn in paperwork needed for recertification or income updates and
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services to help you remain successful in housing, including but not limited to:

- Monthly home visits to identify any needs to support housing stability. Home visits will be scheduled in advance whenever possible and conducted with participant consent except where otherwise authorized by law or program requirements.
- Employment or income support
- Life skills or budgeting help and
- Health or behavioral health referrals

Participation in community events and recreational activities is highly recommended. Residents are encouraged to participate in onsite activities and opportunities offered through community partnerships to build connections, engage with the community, and access additional resources.

3. Program Responsibilities: What the Program Agrees to Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a Case Manager
- Help you understand your lease, if assistance is needed
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need
- Services may include on site services or activities or off-site services and activities in the community
- Tailor services for you based on your need
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan
- Complete monthly home visits to assess any additional needs

What Customized Services means: A flexible bundle of project or partner provided services, supports, and activities selected in collaboration with each participant, based on their goals,

strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Healthcare & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment, financial or other counseling, or income-support navigation
- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies. Translation and language assistance services will be provided as needed to support participants' understanding of program requirements and expectations.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Services

If you do not participate in services:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law. This agreement is not a lease, lease addendum, or occupancy agreement and does not create independent grounds for eviction.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services.

- Non-discrimination
- Ability to file grievances without retaliation

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process. Failure to participate in services does not automatically result in eviction. Any termination from the program, supportive services, or rental assistance will be conducted in accordance with applicable HUD regulations, program requirements, due process protections, and landlord-tenant laws.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and responsibilities of the program and that I may ask questions at any time.

Signatures:

Participant: _____ Date: _____

Staff: _____ Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.



Housing Programs

Resolution Plan

Resident Name: _____

Unit: _____

Date: _____

Purpose of Resolution:

This resolution serves as a supportive plan to assist the resident in addressing lease compliance concerns and supporting housing stability by collaboratively addressing the circumstances that contributed to the situation in a constructive, respectful, and voluntary manner. The plan identifies the areas requiring resolution, actions the resident may take, available services and supports, and the follow-up that will occur. Case management staff will work with the resident to address barriers, encourage engagement, provide appropriate resources, and support progress toward resolution.

The Resolution Plan does not replace, modify, or limit the terms of the resident lease, community policies, program requirements, or any applicable consequences resulting from violations. Its purpose is to provide additional support and opportunities for the resident to address identified concerns, connect with appropriate resources, and take steps toward resolving circumstances that may jeopardize their housing stability.

Concern Summary:

Describe the specific incident, behavior, pattern, or documented concern that resulted in the Resolution Plan. Include relevant dates, observations, resident statements, incident reports, lease or community policy concerns, and prior interventions when applicable.

The summary should be factual, objective, and directly connected to the resident's housing stability, safety, lease compliance, community policies, or program requirements.

Actions to Address:

Residents and case management staff reviewed the following actions intended to resolve the identified concerns and reduce the risk of continued violations or loss of housing:

- 1.
- 2.
- 3.
- 4.
- 5.

Actions should be directly related to the identified concern and reasonably achievable by the resident.

Guidance for staff: examples may include correcting a lease violation, complying with guest policies, substance use, removing prohibited items, addressing behaviors that disrupt the community, participating in meetings with staff regarding ongoing concerns, developing a safety or crisis plan, or taking other reasonable actions necessary to return to compliance

Services and Supports Offered

Case management staff discussed and offered the following services, resources, or support to assist the resident in successfully addressing the identified concerns:

- ☐ Substance use treatment or recovery services
- ☐ Behavioral health services
- ☐ Medical services
- ☐ Crisis services or safety planning
- ☐ Benefits assistance
- ☐ Peer support or recovery groups
- ☐ Increased case management contact
- ☐ Transportation assistance
- ☐ Support addressing unit health, safety, or sanitation concerns

- ☐ Anger management, conflict resolution, or emotional regulation support
- ☐ Connection to a community treatment provider
- ☐ Other: _____

Specific referrals, services, or support offered:

Staff will continue to provide outreach, address barriers to participation, revisit available options, and provide additional opportunities for engagement when appropriate.

Resident Response and Choices

The resident:

- ☐ Agrees to participate in the following recommended services or supports:

- ☐ Declines the following recommended services or supports at this time:

- ☐ Requested alternative services, supports, or strategies:

Follow-Up and Staff Responsibilities

Housing Services staff will:

- ☐ Meet with the resident weekly
- ☐ Meet with the resident biweekly
- ☐ Meet with the resident monthly
- ☐ Provide additional outreach when the resident does not engage
- ☐ Follow up on referrals or service connections, when authorized by the resident
- ☐ Information shared with Property Management will be limited to information necessary to address lease compliance, health and safety concerns, or program administration and will be handled consistent with applicable confidentiality requirements.
- ☐ Review progress toward resolution of the identified concerns
- ☐ Adjust engagement strategies and available supports when barriers are identified
- ☐ Other: _____

Next scheduled follow-up date: _____

Progress and Resolution

Progress will be evaluated based on whether the identified concerns have been resolved, whether additional violations or concerning behaviors have occurred, and whether the resident is taking reasonable steps to address circumstances placing their housing stability at risk.

When concerns continue, Housing Services staff will review barriers, provide additional opportunities for engagement and support when appropriate, and coordinate with Property Management regarding continued lease or community policy violations.

Documented violations will be addressed through established Property Management procedures and applicable lease requirements.

Resident Comments

Acknowledgment of Receipt

My signature acknowledges that this Resolution Plan was reviewed with me and that I received a copy.

Resident Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Service Participation Agreement _Template

Project Name: _____ Participant Name: _____

Unit/Room: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement outlines the expectations for supportive services for participants residing in the project. These services are designed to help you obtain and maintain housing stability, increase income, improve health and well-being, and successfully exit to permanent housing. This agreement complies with Housing and Urban Development (HUD) 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals. Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Participant Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Work on your goals
- Solve problems early
- Understand your housing responsibilities
- Keep your housing stable

Your case manager will also help with referrals, benefits, employment services, and other supports that fit your needs.

B. Work on Your Housing Stability Plan

You and your case manager will create a Housing Stability Plan. You agree to:

- Set and take steps toward your goals (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc)
- Discuss strategies for achieving set goals and target dates for achievement
- Discuss the services available to you, when and how often they are provided, and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- At Rooted in Grace Transitional Housing, you follow a weekly schedule reflecting up to 20 hours of options (or prorated hours if you are employed)
- Follow up on referrals and attend appointments
- Engage in housing retention activities, if necessary
- Turn in paperwork needed for recertification or income updates
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that you and your case manager identify as helpful to help you remain successful in Rooted in Grace Transitional Housing, including but not limited to:

- Employment or income support
- Life skills or budgeting help
- Health or behavioral health referrals

Participation in supportive services is voluntary and encouraged; your housing does not depend on how many services you use. You will not be required to participate in disability-related services unless the purpose of the program is to provide substance use treatment, as allowed under federal regulations.

3. Program Responsibilities: What the Program Agrees to Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a case manager
- Help you understand your lease, if applicable
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need
- Rooted in Grace Transitional Housing provides 20 hours per week of customized supportive services
- Services may include project-based, partner-delivered, or participant self-directed activities, and will be delivered on-site, off-site, or virtually
- Tailor services for you based on your needs
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project- or partner-provided services, supports, and activities selected in collaboration with each participant, based on their goals, strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Health & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment, financial or other counseling, or income-support navigation
- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. If You Choose Not to Participate in Services

Supportive services are voluntary. Choosing not to participate in services will not, by itself, result in the loss of your housing or program assistance. If you are not engaging, staff will check in, seek to understand any barriers, and work with you to re-engage in a supportive, trauma-informed way. You may request a reasonable accommodation at any time. Your continued participation in the program is based on meeting your occupancy/lease requirements — not on the number of services you use. Any termination of assistance follows the due-process, notice, and appeal protections in 24 CFR 578.91 and the program's client-rights policies. This agreement does not replace your lease; lease violations are subject to the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation, you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline supportive services
- Non-discrimination
- Ability to file grievances without retaliation
- Request an exemption from or proration of service participation requirements if you are employed, over the age of 62, and/or have a qualifying disability under 24 CFR 8.3 or developmental disability under 24 CFR 578.3

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgment

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the program's responsibilities, and that I may ask questions at any time.

Signatures:

Participant: _____

Date: _____

Staff: _____

Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.

Sojourner Center's Transitional Housing Service Participation Agreement

Project Name: _____ Participant Name: _____

Unit/Room: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement outlines the supportive service expectations for participants residing in Sojourner Center's Transitional Housing Program. These services are designed to help you obtain and maintain housing stability, increase income, improve health and well-being, and successfully exit to permanent housing. This agreement complies with Housing and Urban Development (HUD) 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what the program agrees to do to support your housing stability, safety, and progress toward your goals. Our goal is to help you stay safely housed, improve your well-being, and connect you with services that support long-term stability.

2. Participant Responsibilities: What You Agree to Do

A. Meet with Your Case Manager

You agree to meet with your case manager on a regular schedule. These meetings help you:

- Create and work on your goals
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your case manager will also help with referrals, benefits, employment services, and other supports that fit your needs.

B. Work on Your Housing Stability Plan

You and your case manager will create a Housing Stability Plan. You agree to:

- Create and take active steps toward your goals. (housing stability, improved health and wellness, increased employment income leading to financial stability and self-sufficiency, etc.)
- Provide regular updates to your case manager about your goals.
- Discuss strategies for achieving set goals and target dates for achievement
- Discuss the services available to you, when and how often they are provided and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- Follow a weekly schedule reflecting up to 20 hours of options (or prorated hours if you are employed)
- Follow up on referrals and attend appointments
- Engage in housing retention activities, if necessary
- Submit all required documentation as requested
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that you , in partnership with your case manager, identifies as necessary to help you remain successful in housing, for at least 20h/week, including but not limited to:

- Employment or income support
- Life skills or budgeting help
- Health or behavioral health referrals
- Psychoeducational groups

You will not be required to participate in disability-related services unless the purpose of the program is to provide substance use treatment, as allowed under federal regulations.

3. Program Responsibilities: What the Program Agrees To Do

A. Provide Customized Support and Case Management

The program will:

- Assign you a case manager
- Help you understand your lease
- Support you in creating and following your Housing Stability Plan
- Connect you with the services you want or need
- Provide 20 hours per week of customized Case Management services
- Services may include project-based, partner-delivered, or participant self-directed activities, and will be delivered on-site, off-site, or virtually
- Tailor services for you based on your need
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project or partner provided services, supports, and activities selected in collaboration with each participant, based on their goals, strengths, needs, and readiness. Customized services may include any combination of:

- Case management, service coordination, housing stability planning
- Employment and education services, job readiness, training, or skill development
- Life skills, budgeting, nutrition, household management
- Health & behavioral health treatment services, including arranged appointments, care coordination, wellness groups
- SUD treatment or recovery supports, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Pet companion services including pet daycare and referrals for pet medical care
- Psychoeducational support groups
- Childcare through the on-site Child Development Center
- Benefits enrollment, financial or other counseling, or income-support navigation
- Community integration activities, recreational or therapeutic programming
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

The program will explain rules and expectations in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Required Services

If you do not participate in services required by the program:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation if you qualify
- You, in partnership with staff will create a plan to meet the requirement before considering discharge from the program

If you continue to not participate in required services, **you may lose program assistance**, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services.
- Non-discrimination
- Ability to file grievances without retaliation
- Request an exemption from or proration of service participation requirements if you are employed, over the age of 62 and/or have a qualifying disability under 24 CFR 8.3 or developmental disability under 24 CFR 578.3

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the responsibilities of Sojourner Center's Transitional Housing Program and that I may ask questions at any time.

Signatures:
Participant: _____

Staff: _____

Date: _____

Date: _____



Program Agreement Update Notice

Save the Family Foundation of Arizona is proposing a Rapid Rehousing project that will serve families experiencing homelessness following domestic violence. The attached Rapid Rehousing Program Agreement reflects the organization's current RRH program model. If awarded funding, Save the Family Foundation of Arizona will revise the agreement prior to project implementation to align with the requirements of the proposed project, including:

- Service to households referred through Coordinated Entry who have experienced domestic violence;
- Required participation in supportive services outlined in each household's Housing Stability Plan;
- Trauma-informed service delivery and safety planning;
- Additional program expectations specific to the proposed project.

Save the Family Foundation of Arizona has established policies and procedures for implementing supportive service engagement requirements and will incorporate those requirements into the project-specific participant agreement prior to program implementation.



Rapid Rehousing Participant Contract

Program Overview

Save the Family's Rapid Rehousing Programs provide short-term rental assistance and intensive support services to help homeless families quickly transition into stable housing. These services aim to help families achieve housing independence and reach their full potential. As a participant, I understand that to remain eligible, I must comply with the following program rules and guidelines discussed in this document.

Program Rules & Expectations

- The goal of the Rapid Rehousing program is to help my family achieve housing stability and long-term self-sufficiency. This includes working toward regular income so I can maintain my housing after program assistance ends.
- I understand that I am responsible for contributing toward my rent as outlined in my case plan. My eligibility for rental assistance will be reviewed each month based on my income and participation in the program.
- Rental assistance is provided through a step-down program. This means the amount of rental assistance will gradually decrease over time as my household prepares to take on more of the rent. My family will gradually become responsible for paying a portion of the rent and will be responsible for the full rent amount by the end of the program.
- I am responsible for managing my household expenses that are not covered by the monthly rental subsidy provided by Save the Family.
- Save the Family will pay approved move-in costs, including utility deposits.
 - One time Security Deposit will be paid to the property directly. Upon move out, any refundable deposit will be refunded to you directly.
 - Ongoing monthly utility payments could be the client's responsibility based on the assistance level approved.
- My family will gradually become responsible for paying a portion of the rent and will be responsible for the full rent amount by the end of the program.
- I understand that rental assistance should not be fully relied on because federal funding is not guaranteed. I understand this means I should be looking for a unit that I will be able to afford once the assistance has ended.
- Adding Household Members: Only the household members listed on my original housing referral are approved for Rapid Rehousing. If an adult joins my household after move-in, I may be considered to have voluntarily exited the program and may receive a 30-day notice of termination. Minor children may be added on a case-by-case basis with Save the Family approval and must be added to the lease to remain in compliance.
- The funder source of _____ will have access to information if requested during a contract monitoring.

Initial _____



**save the
family**
FOUNDATION OF ARIZONA

HOM Inc Briefing

Save the Family contracts HOM Inc to assist with the lease up process and to make payments directly to landlords on their behalf. They also complete the HQS inspection on each unit and ensure rental rates meet program standards.

You will be notified of the date and time of your briefing appointment with HOM, Inc. Please note that all adults (18 and older) are required to attend. You must also bring any requested documentation to the appointment. Failure to provide the required documents may result in your briefing appointment being canceled.

This briefing is required and is where you will obtain your authorization form for your housing search.

- Keep in mind UNIT SIZE will be determined at this meeting and is strictly based on HUDs Occupancy Standards
- You can go down in bedroom size but will not be able to increase initial bedroom size approval

If unable to attend this briefing, you must contact Save the Family Staff to reschedule. After 3 missed meetings, you will no longer be eligible for this program.

Initial _____

Housing Search Expectations

- Find housing within 30 days of HOM Inc Briefing
- Maintain weekly contact with my STF Housing Navigator. Failure to maintain contact may affect program eligibility.
- Address any housing search challenges directly with my Housing Navigator.
- Keep a Log of housing search. ONLY apply at the unit that you are interested in AND has an immediate availability. You should ONLY apply for one unit at a time.
- If Needed- you can Request a 30-day extension however you must provide a search log and show that you stayed in consistent contact with the Housing Navigator. Extensions are NOT guaranteed.
- I understand that Save the Family staff will need to communicate with various housing providers (landlords, property managers, etc) during my housing search. This is required to ensure efficient housing placement.

Initial _____

Housing & Lease Requirements

This will all be reviewed again during your Briefing at HOM Inc

Once you identify a Unit these are the next steps:

- Submit application with property management directly
 - If the property declines your application, you will then need to look for another property
 - If the property approves your application, you will continue to the next steps
- Property will submit a RFTA to HOM Inc with all the required details of the unit
- IF the unit passes Fair Market Rent Requirements AND Rent Reasonableness requirements, HOM Inc will schedule an Inspection with the property directly



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- If the unit FAILS inspection the landlord will have to fix the issues so the unit can pass. If they landlord refuses to fix the items, you will need to look for another unit
- When the UNIT passes inspection:
 - You will be notified by the Housing Navigator that the unit passed inspection
 - DO NOT sign a lease unless you speak to the Housing Navigator to confirm passed inspection. If you sign before a passed inspection, you will be locked into a lease that we CANNOT assist with.
 - You will need to set up any utilities and provide the information to the Housing Navigator
- Keep in mind the program requires a ONE Year lease
- Once you are housed the Housing Navigator will assign you to Housing Case Manager

Initial _____

Program Participation Requirements once housed

- Housing Responsibilities
 - ✓ Follow all lease terms & maintain my rental property.
 - ✓ Communicate regularly with my landlord/property manager.
 - ✓ Participate in in-home visits/home inspections with my assigned caseworker.
- Budgeting & Money Management
 - ✓ Complete an initial intake meeting to set a budget with Client Resource Coordinator
 - ✓ Attend and participate in monthly budget review meetings.
- Case Management
 - ✓ Monthly home visit with home inspection
 - ✓ Submit paystubs monthly
 - ✓ Provide documentation as requested by case manager

Your Assigned Case Manager will assess your various needs and offer referrals to Save the Family Services to include:

- Employment & Career Services
- Mental Health & Substance Abuse Support
- Youth Services

You can choose to decline these additional services however, as it is identified that these areas are still barriers towards Self-Sufficiency, they may be offered multiple times during your time in the program

- I understand that once housed Save the Family will be in regular communication with my landlord / property management company to ensure I am remaining in good standing with my lease and my tenancy.

Initial _____



save the family
FOUNDATION OF ARIZONA

Termination of Subsidy

- Termination of subsidy and participating with Save the Family program can occur for the following reasons:
 - I understand that the subsidy can be terminated if I fail to meet the program requirements outlined in this agreement.
 - If the family has engaged in or threatened abusive or violent behavior toward Save the Family or HOM personnel.
 - If you violate any obligations under the program and/or go 30 days or longer with no communication with your assigned members of the team.
 - If you fail to sign and submit consent forms and other required documentation
 - The landlord chooses to evict based on lease violations
 - You are no longer occupying the unit within the agreement
 - If any member of the family commits fraud, bribery or any other corrupt or criminal act in connection with any Federal housing program.
 - If the household no longer has minimally 50% custody or guardianship of a minor child in the home.
 - Federal funding is maxed out or ends
 - I understand that I will be notified of termination of subsidy and termination of the program by mail, email and or verbally.

Initial _____

My signature below is acknowledging I fully understand the requirements to participate in the Save the Family Rapid Rehousing program. My signature also confirms that all documentation provided to Save the Family staff is true, accurate and complete to include all identification and income information provided.

Printed Name: _____

Signature: _____ Date: _____

STF Staff Signature: _____ Date: _____

My assigned Housing Navigator is:

Housing Navigator	Phone Number	Email
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Save the Family does not discriminate on the basis of race, color, religion, age, national origin, sex, disability, sexual orientation or political affiliation and makes reasonable efforts to accommodate the physically challenged upon notification.

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, *Save the Family (STF)* prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. STF must make reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means that if necessary, STF must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that STF will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that, you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if possible. To request this document in alternative format or for further information about this policy please contact: Save the Family @ 480.898.0228. Para obtener este documento en otro formato u obtener información adicional sobre esta política Save the Family @ 480.898.0228

www.savethefamily.org

125 E. University Dr., Mesa, AZ 85201 | p: 480.898.0228 | f: 480.898.9007

Tax ID: 86-0665712 | QCO Code: 20320



Reasonable accommodations available upon request.
TTY SERVICES 1-800-367-8939





Support Services Agreement – Step Up

Participation with the following services are required for ongoing assistance with Step Up Program.

Service	Client Initials
Ongoing Case Management to include: • Twice a Month Home Visits • Resource Connection • Support Service Connection listed below	
Mental Health and Substance Abuse Services Participate with identified services to include participation with established assessment schedule and resource connection	
Budgeting and Financial Management Participate with identified services to include participation with established assessment schedule and resource connection	
Career Services / Workforce Development Participate with identified services to include participation with established assessment schedule and resource connection	
Youth Services Participate with identified services to include participation with established assessment schedule and resource connection	

Level of Assistance for all Support Services will be determined by Case Management based on the individualized needs of each household.

As stated in the Occupancy Agreement:

1. Maintaining income through full time employment that will support locating and identifying permanent affordable housing in the community.
 - a. Employment is a requirement of the program, if at any time employment is lost, Client must meet with their career coordinator weekly to obtain employment and may be required to come into the office to meet in the career center for onsite support.
 - b. For Clients employed full time, they will need to meet with their career coordinator and client resource coordinator as outlined in their case-plan to discuss career goals, income, budget needs and ensure that the employment meets the needs of the family.
 - c. If at any time it is determined that Client is unable to work while enrolled in the program, they will need to provide written documentation explaining why they are not able to work and the STF team will work with the Client on finding alternative housing, due to needing to terminate from the program if they are unable to work.
2. Client must have a minimum of 50% custody of children in the home.



3. Meeting with a Case Manager to address any barriers to permanent housing two times a month, one of those in the home. While meeting with the assigned Case Manager, work on developing a service plan and goals to work on while enrolled in the Step Up program.
4. Clients will participate in ongoing regular budgeting. This includes attending financial literacy programming, setting up an initial savings account with STF, and mandatory monthly participation of 30% of Adjusted Gross Income in program occupancy fee after month 6 in the program. The client will schedule and complete a ongoing, monthly budget meeting with the Client Resource Coordinator. Initial meeting to take place within one month of move in to establish a sustainable wage needed to cover all expenses in preparation for a move into community housing at the conclusion of the program to achieve self-sufficiency.
 - a. Budget meetings will focus on addressing any debt concerns that directly impact housing stability, including but not limited to, outstanding eviction judgments and utility fees. The client agrees to include a plan in their budget to reduce debt and increase savings by adhering to the budget plan, limiting discretionary spending that is not directly related to maintaining housing stability and avoiding taking on additional debt (leasing a vehicle, credit cards, rent to own furniture). The client will be responsible for active engagement in budget meetings and accurately tracking their income and expenses on the budgeting tools provided.
5. Client will participate in ongoing regular career services. This includes a mandatory initial meeting with the Career Coordinator/Supervisor and attending ongoing meetings re: job retention. If a client is not employed, meeting with the Career Coordinator/Supervisor to obtain employment and attending career center classes as outlined in your services plan is required. Part of Agency's program is to equip the families for successful employment including: to obtain a birth certificate, social security card and AZ driver's license or photo ID, provide an opportunity for the Client to participate in services such as resume building, mock interviews, etc. and to have a resume that will enhance their career opportunities, help Client establish child care or after school care for their children, and help Client to be able to provide medical documentation if there are limits to their work abilities. Client must complete and submit all required documentation on time.
6. Completing Adult and Child Assessments as outlined in the case plan, attend both in-house and community services that promote the development and growth of skills which increase the likelihood of maintaining housing stability.
7. Submit all documentation required by the Agency including but not limited to income information, birth certificates, social security cards, current driver's license or picture ID, permanent residency card or work visa, etc.
8. Client must provide income documentation each month to their CM by the 3d day of the month. This includes paystubs, bank statements, or other documentation.
 - a. Documentation that will be needed includes:
 - i. Paystubs (gross income earned)
 - ii. DES Case Assistance Letter (each month)
 - iii. Unemployment payments
 - iv. Child Support
 - v. Social Security payments
 - b. All documents must be submitted- not hand written.
9. Meet with a Case Manager 2x per month, or as required. This will include 1x a month an in-home inspection to ensure the home is kept clean, organized, free of trash build up, holes and well maintained.
10. Sign a waiver allowing the Agency to complete urinalysis testing if requested.



STEP UP TO INDEPENDENCE™ CLIENT PROGRAM AND OCCUPANCY AGREEMENT

This Program and Occupancy Agreement (the "Agreement") is made by and between Save the Family Foundation of Arizona ("Save the Family" or "Agency"), a nonprofit organization, and the family of identified below (the "Client").

The parties recognize that this relationship between the Agency and the Client is unique and that this housing is being offered as part of the social services offered by the Agency under a program designed to help Clients obtain and maintain permanent housing and self-sufficiency once they complete the offered program. As such, this Agreement is specifically excluded from being governed by the Arizona Residential Landlord and Tenant Act per ARS §33-1308(1).

In consideration of the mutual promises herein contained, it is agreed as follows:

GUIDELINES FOR PROGRAM AND HOUSING PARTICIPATION

The Agency provides the Client with housing, case management, and supportive services for a period no less than 6 months, not to exceed 12 months. Any stay past 12 months must be staffed and approved due to significant circumstances with the Chief Programs Officer ("CPO") and client must be actively engaged in program services and working on case plan goals and permanent housing.

Premises: _____

Agency: Save the Family Foundation of Arizona

Client: _____

Authorized Occupants: _____

Authorized Assistance Animal: _____

Housing and services are for the sole use and benefit of Save the Family Step Up to Independence™ clients. Any unauthorized visitors or occupants found on agency property may be cause of termination from the program. The premises are to be used solely by the person listed above and may not be used for any commercial purposes or sublet or rented in any manner.

The Agency must approve all additions, changes, or deletions to household composition. The Agency reserves the right to change unit assignments as necessary, throughout client's stay.

Occupancy Standards:

Dwelling units will be assigned in accordance with the following standards:

UNIT SIZE	MINIMUM OCCUPANTS	MAXIMUM OCCUPANTS
1 Bedroom	1	3
2 Bedroom	1	5

1. The purpose of Save the Family services is to help the Client obtain and maintain permanent housing and self-sufficiency. Participation in the program requires the Client to engage in and complete the requirements outlined below. Maintaining income through **full time employment** that will support locating and identifying permanent affordable housing in the community.
 - a. Employment is a requirement of the program, if at any time employment is lost, Client must meet with their career coordinator weekly to obtain employment and may be required to come into the office to meet in the career center for onsite support.
 - b. For Clients employed full time, they will need to meet with their career coordinator and client resource coordinator as outlined in their case-plan to discuss career goals, income, budget needs and ensure that the employment meets the needs of the family.
 - c. If at any time it is determined that Client is unable to work while enrolled in the program, they will need to provide written documentation explaining why they are not able to work and the Save the Family team will work with the Client on finding alternative housing, due to needing to terminate from the program if they are unable to work.
2. Client must have a minimum of 50% custody of children in the home.
3. Meeting with a Case Manager to address any barriers to permanent housing two times a month, one of those in the home. While meeting with the assigned Case Manager, work on developing a service plan and goals to work on while enrolled in the Step Up™ program.
4. Clients will participate in ongoing regular budgeting. This includes attending financial literacy programming, setting up an initial savings account with Save the Family, and mandatory monthly participation of 30% of Adjusted Gross Income in program occupancy fee after month 6 in the program. The client will schedule and complete an ongoing, monthly budget meeting with the Client Resource Coordinator. Initial meeting to take place within one month of move in to establish a sustainable wage needed to cover all expenses in preparation for a move into community housing at the conclusion of the program to achieve self-sufficiency.
 - a. Budget meetings will focus on addressing any debt concerns that directly impact housing stability, including but not limited to, outstanding eviction judgments and utility fees. The client agrees to include a plan in their budget to reduce debt and increase savings by adhering to the budget plan, limiting discretionary spending that is not directly related to maintaining housing stability and avoiding taking on additional debt (leasing a vehicle, credit cards, rent to own furniture). The client will be

responsible for active engagement in budget meetings and accurately tracking their income and expenses on the budgeting tools provided.

5. Client will participate in ongoing regular career services. This includes a mandatory initial meeting with the Career Coordinator/Supervisor and attending ongoing meetings re: job retention. If a client is not employed, meeting with the Career Coordinator/Supervisor to obtain employment and attending career center classes as outlined in your services plan is required. Part of Agency's program is to equip the families for successful employment including: to obtain a birth certificate, social security card and AZ driver's license or photo ID, provide an opportunity for the Client to participate in services such as resume building, mock interviews, etc. and to have a resume that will enhance their career opportunities, help Client establish child care or after school care for their children, and help Client to be able to provide medical documentation if there are limits to their work abilities. Client must complete and submit all required documentation on time.
6. Completing Adult and Child Assessments as outlined in the case plan, attend both in-house and community services that promote the development and growth of skills which increase the likelihood of maintaining housing stability.
7. Submit all documentation required by the Agency including but not limited to income information, birth certificates, social security cards, current driver's license or picture ID, permanent residency card or work visa, etc.
8. Client must provide income documentation each month to their Case Manager by the 3rd day of the month. This includes paystubs, bank statements, or other documentation.
 - a. Documentation that will be needed includes:
 - i. Paystubs (gross income earned)
 - ii. DES Case Assistance Letter (each month)
 - iii. Unemployment payments
 - iv. Child Support
 - v. Social Security payments
 - b. All documents must be submitted- not hand written.
9. Meet with a Case Manager 2x per month, or as required. This will include 1x a month an in-home inspection to ensure the home is kept clean, organized, free of trash build up, holes and well maintained.
10. Sign a waiver allowing the Agency to complete urinalysis testing if requested.

PARTICIPANT FEES AND OTHER CHARGES:

Entry and Exit Costs

Non-refundable security deposit of \$800 is due upon entry into the program. If damages are noted upon exit, Client will be responsible for paying repairs costs exceeding the non-refundable security deposit. Damages will be deducted from any Occupancy Saving Contributions.

Monthly Costs

The Occupancy Base Fee and Occupancy Saving Contribution Fee together are referred to as the "Occupancy Fee".

Occupancy Base Fees (Base) are **\$800 a month**. Save the Family will waive the occupancy fee for the first full month in the program. Occupancy fees are due on the 5th of each month.

- Late fee of \$75 will be charged to account on the 6th regardless of whether the 5th falls on a weekend or holiday. (effective: 7/1/23)
- Any outstanding balance at the end of a month will generate a 30 day exit/termination letter to be provided to the Client (copy to be given to accounting) by the Step Up™ Manager/Case Manager. 30 day notices may be cancelled upon the approval of the CPO (written notification necessary: email approval from CPO to accounting email address will be needed if account is paid in full.
- No partial payments are accepted without a written approved and executed payment plan (promissory note). MUST BE APPROVED BY CPO. Promissory note must be provided to accounting to inform them of the plan to pay.

Occupancy Saving Contribution Fee (Savings) are variable and are in addition to the Occupancy Base Fee. Saving fees begin and are due on the 5th of month 6 in the program (to avoid late fee).

Variable costs are calculated as 30% of the average adjusted income for the two months immediately before the beginning of the assessment period. The Step Up™ Case Manager will set the Savings fee at the following intervals:

- Assessment Period 1: Fee effective for months 6-12
- Assessment Period 2: Fee effective for months 13-18, *CPO preapproval required*
- Assessment Period 3: Fee effective for months 19-24, *CPO preapproval required*

Individual Case Plans are valid for 12 months and require CPO approval for Assessment Period 2 and 3. Saving fee may be modified to current income levels outside an assessment period if the Client experiences a qualifying life event (change in job, income, family status [marriage, divorce, birth of child, etc.]). Modifications must be staffed with the CPO and the accounting team must be notified by submission of the modified occupancy fee form upon approval.

Client's Use of Saving Contribution Fees while in the program Debt Payments: All fees owed to the agency must be paid prior to paying other debts. While in the program the Client will work to decrease any outstanding debts that may impede long term housing in the community. Clients may use 50% of any excess savings balance to retire debt.

- ☐ To stay program compliant, client will need to show proof of debt being paid with savings.

Minimum Saving Contribution Fee Balance: Savings equal to first/last month's rent and security deposit for fair market rent in the community.

Excess Savings Balance: Total savings balance less the minimum savings contribution fee balance.

M-POWER ALLOTMENTS

SRP M-Power Plans are used for all Step Up™ Units. Save the Family provides a subsidy based on SRP Energy Estimator, which varies based on the time of year and size of the unit. The Save the Family allotment are added to your meter each month electronically, around the middle of the month.

Clients pay amounts over the subsidy allowance.

Failure to maintain electricity in the home is a material breach of this Agreement. Client is required to use all utilities for normal household purposes only and not for any commercial purposes.

You can check your usage on the **SRP M-Power App**.

Account Number _____

If you are not able to live within the MPower monthly allotment provided by Save the Family, you must purchase additional power on your own.

An example below of power usage by day:

Month & Day	Power Used Today	Daily Allotment From Save the Family	Over (+) / Under (-) Daily Allotment	Remainder of my Monthly Allotment as of Today
April 1	\$2.45	\$1.96	+ .49	\$52.55
April 2	\$3.20	\$1.96	+ \$1.24	\$49.35
April 3	\$1.76	\$1.96	- .20	\$47.59
April 4	\$4.75	\$1.96	+ \$2.79	\$42.84
April 5	\$2.55	\$1.96	+ .59	\$40.29
April 6	\$2.80	\$1.96	+ .84	\$37.49
April 7	\$3.60	\$1.96	+ \$1.64	\$33.89

First, you can see that monitoring your utilities requires you to do simple math. Second, you can see that after only one week, you have used too much power. You can now calculate the daily power left for the month by dividing the remaining allotment of \$33.89 by 21 remaining in the month (\$33.89 divided by 21 days = \$1.58 per day).

In order to manage utility costs for the rest of the month, you have two choices:

1. Reduce daily utility usage to \$1.58/day
2. Purchase more power on your account.

HOUSING RULES:

A. Safety Concerns:

1. Save the Family Policy states that any identified abuser(s) must not be informed by Client, Client's relatives, friends, or associates of Client's address. Client may be terminated from the program if the abuser is found on Save the Family property or if Client fails to immediately report any attempts by the abuser to contact Client. Child visitation with the abuser cannot take place on Save the Family property, including pick-up and drop-off.

2. Client must notify the proper authorities in case of emergency. Examples of proper authorities include 911, Police Department, Fire Department and Poison Control. Client must then notify their Case Manager of all safety and other concerns.
3. After hours property maintenance emergencies are defined as fire or flooding, only. The Agency's emergency phone number is (480) 310-6043. All other maintenance related issues should be entered as a work order in Buildium or call and leave a message at 480-282-2524.
4. Client agrees to participate in a fire evacuation plan. See below.

B. Crime Free Concerns:

1. Client must refrain from any violent behavior, including physical or verbal abuse, or threats of any kind. Additionally, Client must refrain from any harassing or intimidating behavior.
 - a. Criminal activity, including the use of illegal drugs of any kind, is prohibited on or near premises. Additionally, drug related criminal activity means the illegal manufacture, sale, distribution, use, giving, transferring, or possession of any illegal or controlled substances as defined in Section 102 of the Controlled Substance Act (21 U.S.C. 8021).
2. MARIJUANA IN ANY FORM IS EXPRESSLY PROHIBITED because the Agency has determined that the use, possession, distribution, growing or manufacturing will interfere with the health, safety, welfare and right to peaceful enjoyment of others and is contrary to the policies and programs created by Save the Family. Clients agree to notify their household and guests of this special policy and acknowledge that any state law that would otherwise permit the use of marijuana is specifically not applicable in this voluntary housing program.
3. Client agrees to not engage in any act intended to facilitate criminal activity, to not permit the dwelling unit to be used for or to facilitate any criminal activity, including but not limited to criminal gang activity, threatening or intimidating actions, assault, unlawful discharge of a weapon, or any activity that otherwise jeopardizes the health, safety, or welfare of the Agency, their agents or representatives, other clients or neighbors, or that involves imminent or actual serious property damage.
4. Weapons of any kind are not permitted in Client housing, on Agency property, or at Agency functions.
5. A violation of any provision in this section of the Agreement by the Client, any occupant or guests on the premises shall be grounds for the immediate termination of this Agreement and shall require the Client to immediately vacate the dwelling unit.

C. General Rules

1. Guests may not stay at the premises for more than three (3) days in any six month period. Guests may not receive mail at the Premises and are prohibited from listing this address as their residence or receive any mail. Any guests that routinely visit the Premises to provide support to the family must be disclosed in writing, complete a background screening as a necessary term to visit the property, and be approved by Agency.
 - i. Save the Family is part of the Smoke-Free Arizona Act, A.R.S. § 36-601.01, which prohibits smoking in most enclosed public places and places of employment. As such, smoking is expressly prohibited, including cigarettes, cigars, pipes, hookahs, electronic cigarettes, etc.
 - ii. Client must notify the case manager prior to being absent from the housing unit for more than 2 weeks.

2. Due to national bed bug issues, Client cannot bring any second-hand furniture or fabrics into the housing unit unless client has thoroughly inspected and cleaned the items first. Save the Family is not responsible for any damages caused by second-hand furniture that is brought into the home.
3. Live Christmas trees are not permitted in housing units. Artificial trees are permitted. Appropriate use of Christmas lights are permitted but must be in safe and working order and in a manner that does not overload any electrical system or create a fire hazard.
4. Pools, aquariums, waterbeds and any other items that contains water of any kind are not permitted.
5. Save the Family has the right to trespass persons off the property at any time that are not listed on this Agreement.
6. Client is responsible for maintaining the unit, keeping it clean, and clutter free.
7. Client is responsible for ensuring the trash is taken out weekly to prevent bugs and critters in the unit.
8. Client is responsible for being respectful, honest and work collaboratively with the staff at Save the Family and ARM of Save the Family.
9. The Agency staff has the right to access the housing unit and does not require Client's presence or approval to enter. Agency staff may randomly conduct property inspections with or without notice.
10. Keep parking areas free of automotive oil, fluids and non-working vehicles. No car repairs or unregistered vehicles are allowed in parking lots. Non-working vehicles are subject to tow at owner's expense.
11. Obtain written Agency authorization before removing any furniture and/or equipment supplied by Save the Family from unit or property. Save the Family property should not be left outside of the housing unit. Nothing can be placed outside of housing unit; this includes, but is not limited to, boxes, patio furniture, bikes, etc. Barbeques and other cooking units are prohibited. If any furniture is removed without Agency approval, the Client will be reported to the police for stolen property and prosecuted.
12. Save the Family does not assume responsibility or safety of donated items or gifts Clients may receive and do not require Client to use them.
 - a. Save the Family is not responsible for the loss/damage of items in a unit. Save the Family also recommends that Client's obtain renters insurance at their own expense.
13. Agency written approval is required for any cable, satellite or internet installations.
14. Save the Family gives a monthly utility allotment and any overage is the Client's responsibility.
15. The Client will be assessed charges for any damages to the unit based on the cost of repair and replacement and/or cleaning.
16. Animals: NO animals (fish, reptiles, birds, dogs, cats, etc.) are permitted with the exception of approved ESA or Service Animals (per assistance animals addendum).
17. Laundry Room Rules: See below
18. Computers are available for use at the Agency for the convenience of Client for the purpose of performing any necessary research about the use of any household furnishings, laundry appliances, or any other reasonable purpose that furthers Client's successful participation in this program.

FIRE EVACUATION PLAN PROCEDURES

Purpose: To provide information to clients regarding fire safety at their housing unit.

Procedure: Evacuation planning at your unit.

- Meet with all members of your family and go over fire procedures
- Identify all exits at your unit
- Decide on a safe distance outside where you and your family can meet in case of smoke or fire
- Identify and educate all family members on the location of the fire extinguisher
- Once a month press the "test" button on the smoke alarm to insure it is working (if not, replace the 9 volt battery)
- Instruct all family members of the location of the emergency numbers

Evacuation Plan:

- Evacuate the house immediately if you suspect smoke or fire
- Meet at your designated area outside
- Make sure all family members are accounted for
- Call 911 and report the fire

LAUNDRY ROOM RULES AND REGULATIONS

The apartments located at 605, 613, 621, 637, 661, 711, 727, and 735 N. Cherry agrees to the following:

Washers and dryers are for the sole use of Save the Family's clients and tenants only. Clients who let other individuals use the laundry room will lose their privileges. Laundry services are a privilege and can be taken away if not followed.

Save the Family is not liable for any loss, damage, or injury to persons or property occurred while using the laundry room.

- ❖ The entry door to the laundry room is to be kept closed and locked while there is not a client in the laundry room attending laundry.
- ❖ You will be provided with a laundry room key. A Replacement Key will be \$25.00.
- ❖ Each resident is responsible for following all operating instructions on washers and dryers.
- ❖ Do not overload washers or dryers. Please measure detergents — too much detergent could damage the washer.
- ❖ Clean the lint catcher before and after using the dryer.
- ❖ Clients are responsible for leaving the laundry room in a neat and orderly fashion after use as well as to shut off the laundry room light.
- ❖ Remove clothes promptly from washer & dryer after each use.
- ❖ Do not remove another person's laundry from the machines.
- ❖ Do not wash or dry comforters, rugs, or other large items.
- ❖ Dispose of any trash (i.e. detergent containers, fabric softener containers/sheets).

- ❖ Any items that contain contaminated or contagious or damaging substances are prohibited.

Please contact property maintenance (arminfo@savethefamily.org) and complete a work order if washer or dryer are not working properly and report any vandalism, theft, drug use or misuse of the facility.

Clients who do not follow the laundry room rules can have their laundry room privileges suspended or revoked.

Save the Family and its staff are not liable for any loss, damage, or injury that may occur while using the laundry room. Client agrees that using the washers and dryers is at their own risk and that they assume full responsibility for any personal injuries that may result from using.

Client agrees to indemnify and hold harmless Save the Family and its staff against any claims or demands, costs or expenses, arising out of or in any way related to his/her use of the laundry room, including but not limited to any personal injuries, damages or other losses that he/she may sustain while using the washers and dryers.

CLIENT PROGRAM RESPONSIBILITIES

1. Client has voluntarily chosen to receive housing, Case Management, and Supportive Services through Save the Family Foundation of Arizona's Step Up to Independence™ Program for my family and myself. Office hours are from 8:00 am to 5:00 pm, Monday through Friday.
2. Client understands that they are required to partake in the Save the Family savings account.
3. Client understands that as a participant in this program, they are required to receive the supportive services provided by Save the Family's Pathways to Stability Program and the Direct Service Personnel which includes my Case Manager.
4. Client understands that their participation in this program does not ensure they will become self-sufficient.
5. Client understands and agrees to work cooperatively with the Staff at Save the Family. Cooperation includes but is not limited to timely sharing of requested information, demonstrated behavioral efforts to complete their Housing Plan, Career and Budgeting goal, the use of planning behaviors and straight forward discussion of barriers.
6. Client understands that their failure to share information may impede their progress and may jeopardize their ability to remain in the program.
7. Client understands that while they are participating in Step Up to Independence™ Program that problems may be discussed that can be upsetting in nature. They understand that such discussions may be necessary to help them overcome their barriers.
8. Client understands that they will be required to take a drug test if there is suspected use of a controlled substance.
9. Client understands that due to the availability of services at Save the Family, the staff does not have the capability to respond immediately to emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines such as:
 - EMPACT 24-hour Crisis Hotline (480) 784-1500
 - EMPACT 24-hour Crisis Hotline (855) 785-1500 (toll free)
 - EMPACT 24-hour Sexual Assault Hotline (480) 736-4949

- EMPACT 24-hour Sexual Assault Hotline (866) 205-5229 (toll free)
 - Rally Point 24-hour Hotline (Veterans and Military) (855) 725-5948
10. Client understands that messages to the case manager will be returned within 24 to 48 hours during regular weekday office hours. Case Managers/ Case Coordinators are not available on weekends.
 11. Client understands that it is their choice to receive Save the Family services and they may terminate services at Save the Family at any time.
 12. Client understands that they will be assigned a case manager throughout their stay at Save the Family. They further understand that if Save the Family deems it necessary, that case manager may be changed and that they will be informed of such a change by the supervisory staff.
 13. Client understands that the client/Save the Family relationship is unique and for the purpose of supporting their goals in obtaining and stabilizing in permanent housing. It is inappropriate for a client or a Save the Family staff member to spend time together socially, to bestow gifts, or to attend family or religious functions. The purpose of these boundaries is to ensure that the Client and the Save the Family staff members are clear in their roles for Client's stay in the program and that confidentiality is maintained.
 14. Client understands that their goals are reviewed bi-monthly during Save the Family Case Plan staffings. The Team includes the client, Client Resource Coordinator, Case Manager, Career Development Coordinator and the Youth Advocate.
 15. Client further understands that information from the Case Plan staffing may be conveyed to the Save the Family Administrative staff as it may affect day-to-day business functioning for the Agency. Client can direct questions concerning the oversight of their case to the Save the Family Chief Programs Officer, who supervises that case.
 16. Client understands that ordinarily all communications and records created in the process of participation in Save the Family services are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statutes. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. There are also numerous other circumstances when information may be released including but not limited to when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against Client, to comply with worker compensation laws, and to comply with the USA Patriot Act. The rules and laws regarding confidentiality are numerous and complex. Client understands they have the right to review their own records and to insert their own statement into that case record. Furthermore, if personnel insert statements in response, Client will be informed and given a chance to review such a response. Client understands that federal, state, and local laws require that the Save the Family staff report all cases of physical or sexual abuse or neglect of a minor or the elderly. Client understands that federal, state and local laws require that the staff report all cases in which there exists a danger to self or others. The client understands that although the staff is bound by confidentiality, other clients and/or class members are not bound by such restrictions.

CLIENT PROGRAM RIGHTS

Client understands that they have the following rights as a participant in this program:

- ☐ To be informed of all their rights in English or in Spanish.
- ☐ To have impartial access to services regardless of race, religion, gender, sexual orientation, education, age, or physical, mental or sensory impairment.

- ☐ To be provided humane care and protection from harm, abuse, or neglect and without discrimination.
- ☐ To file a grievance and not to be discriminated against for doing so.
- ☐ To be informed in advance of fees where applicable.
- ☐ To examine my file under supervision, unless clinically contraindicated. Such determination will be documented in the client file.
- ☐ To be informed of the various steps and activities involved in receiving services through Save the Family.
- ☐ To confidentiality under federal, state, and local laws relating to the receipt of services.
- ☐ To make an informed decision whether to accept or refuse participation in services.
- ☐ To contact and consult with counsel at my own expense and to be informed of the process of Save the Family client grievance procedures regarding treatment.
- ☐ To receive an individual Action plan, designed with my assistance to meet my particular needs. This plan will be reviewed, improved and/or changed depending on information discussed during home and office visits with my case manager.
- ☐ To have the opportunity to provide feedback on my satisfaction regarding program process and services.
- ☐ Domestic Violence survivors retain the right to choose when, how and what personal information will be shared, or not shared, and with whom. Agency and advocates are responsible for respecting and honoring the victim's wishes and safeguarding any of the survivor's information that they collect or hold.

THE MCKINNEY-VENTO HOMELESS ASSISTANCE ACT

Whom do I contact to assist with my child's education?

Every school district has a local homeless education liaison. This person can help you decide which school would be best for your child and communicate with the school. The local liaison also can assist your child with school supplies, supplemental and community services, free school meals, and set up transportation.

When you enroll your child in a new school, you should ask to meet his/her teacher(s). You should also speak to your child's teacher or school counselor every so often to learn about how your child is adapting to his/her new school. You can also share information about how your child is behaving at home or things he or she is dealing with that might affect his/her schoolwork.

What questions should I ask regarding services under McKinney-Vento?

- ❖ Who is the local homeless education liaison? How can I contact him or her?
- ❖ What transportation is available for my child to stay in the same school (the school of origin)?
- ❖ If my child changes schools, who can assist me transfer my child's transcripts?
- ❖ How can my child receive free meals at school?
- ❖ How can my child receive free school supplies, if needed?
- ❖ Who can help if my child needs special education services? How quickly can these services be set up?
- ❖ What academic help is available for my child, such as Title programs or after-school tutoring?
- ❖ What programs can help develop my child's talents and address his/her unique needs?

- ❖ Are there sports, music, or other activities available for my child?
- ❖ How can my child go on class field trips or participate in other school activities if I can't pay for them?
- ❖ Is there a preschool program for my younger children?

RIGHTS AND RESPONSIBILITIES UNDER THE MCKINNEY-VENTO ACT

Children's Rights	Parent's Responsibilities	Schools' Responsibilities
❖ Children experiencing homelessness have these rights: ❖ A free, appropriate public education. To remain in the school of origin before becoming homeless, or where last enrolled. ❖ To enroll in the school where other children in their current neighborhood are assigned to attend. *To enroll without complete or verified documents. ❖ Comparable academic, social, psychological, transportation, and other supports that other students receive, even if the school is not a Title.	❖ Parents experiencing homelessness have these responsibilities: ❖ To enroll their children in school. To ensure their children attend school regularly. *To properly immunize their children. ❖ To keep copies of documents important to school enrollment. ❖ To learn about their children's right. ❖ To learn their own rights. ❖ To participate in school activities.	❖ Schools serving families experiencing homelessness have these responsibilities: *To remove all barriers to enrollment, attendance, and school success. ❖ To inform families of their rights and to uphold them. ❖ To coordinate the enrollment and transfer process. To reach out to families with information, advocacy and support. ❖ To teach to high standards for all students. ❖ To provide for the immediate

The Community Youth Advocate for Save the Family can offer support to utilize McKinney Vento Services that you may need. If you have any questions regarding McKinney Vento services, you are encouraged to contact

McKinney-Vento Act School Liaison Contact Information:

- ❖ Chandler Unified School District — (480) 883-5980
- ❖ Gilbert Unified School District — (480) 832-3034 ext. 307
- ❖ Kyrene Elementary District - (480) 541-1520 or (480) 541-1523
- ❖ Mesa Unified School District - (480) 472-0291 or (480) 472 0295
- ❖ Queen Creek Unified School District - (480) 987-7482
- ❖ Scottsdale Unified District — (480) 484-6239
- ❖ Tempe Elementary School District — (480) 730-7481
- ❖ Tempe Union High School District — (480) 345-3767

If you need contact information for a school that's not listed above, you can contact the State Coordinator for Homeless Education at (602) 542-4963.

In accordance to U.S. Federal Law - Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.) I agree to ensure any child in my household who is of school age and is under the age of 18 years old are enrolled in school. I will provide proof of enrollment within 30 days of lease up or move-in or upon receipt of this notice. I also agree to ensure my child continues to be enrolled in school. The Community Youth Advocate at Save the Family checks enrollment quarterly.

RELEASE OF LIABILITY & WAIVER OF ALL CLAIMS: HOUSEHOLD FURNISHINGS

Policy:

Save the Family occasionally is able to provide furniture and home furnishings, including but not limited to baby furniture and products, for client use. These items are typically provided through donation and Save the Family cannot guarantee the safety or stability of these items.

Client Responsibilities:

- ❖ Client may accept or reject household furnishings offered to them by Save the Family. Should the client accept these household furnishings, the client understands and agrees that:
 - Client is responsible for inspecting household furnishings to check for defects or dangerous conditions.
 - Client is responsible for determining if a particular item has been the subject of a product recall.
 - Client is responsible for obtaining user manuals as needed.
 - Client assumes the risk of using household furnishings.
 - Computers are available to use at Save the Family for the convenience of client to perform any necessary research about the household furnishings.
- ❖ Release of Liability & Waiver of All Claims:
 - Should the client accept household furnishings, the client understands and agrees that:
 - Client releases Save the Family, Save the Family's staff, agents and insurers from any and all legal liability or claims relating to client's acceptance of, possession of, use or misuse of household furnishings, including claims relating to any damage to person or property, disability, injury or loss, including death, arising from the use of any household furnishings or the failure of the household furnishings to function as intended by the manufacturer.
 - Client shall indemnify and hold harmless Save the Family, Save the Family's staff, agents and insurers from any claim(s) arising from the clients use, operation or possession of household furnishings.
 - Client assumes all responsibility for household furnishings provided by Save the Family that he/she has accepted for use.
 - Client has read this Release of Liability & Waiver and of All Claims, understands its contents, and agrees to abide by its provisions.

SERVICE AND EMOTIONAL SUPPORT ANIMALS ADDENDUM

Landlord hereby agrees to allow you to have a Service or Emotional Support Animal as a reasonable accommodation.

Name of animal: _____ Gender of animal: _____

Type of animal: _____ Breed: _____

Tenant understands that this addendum applies only to the specified animal noted above and that no other animal may be substituted for the above-named animal without prior written authorization of the landlord.

All animals must be walked on a leash at all times and the pet is not allowed to be chained or tied to the exterior part of the building at any time. Resident is responsible for the proper disposal of all animal waste. Resident acknowledges that if animal waste is not properly disposed of the resident can be fined for the cost of disposal.

Landlord will not charge any pet fees, pet rent or a security deposit for your service, support or emotional support animal. However, the Resident will immediately notify Step Up™/Save the Family of any personal injury or property damage caused by the animal. Any damage attributed to the animal will be paid promptly by the resident.

Resident shall be required to show proof that his/her animal has been properly vaccinated for rabies and that all local licensing requirements have been met. Resident will be solely responsible for maintenance of the animal in a healthy environment and will ensure that the animal receives proper standard care and humane treatment. Resident represents and affirms the service, support or emotional support animal does not pose a direct threat of harm or is a danger to any persons and will not cause damage to the Property.

At no time will a animal be allowed in lobbies, offices or common areas of the Save the Family Buildings, unless an ADA accommodation requires the animal be with the resident in these areas. It is Save the Family and Step Up™ to Independence policy that all tenants be allowed quiet enjoyment of the premises and no animal will be allowed or permitted to remain that constitutes a nuisance or threat to staff or detracts from any neighbor's quiet enjoyment of his/her home.

Any service or emotional support animal(s) having offspring must be brought to the immediate attention of the landlord.

Any change of animal will require a new agreement.

Tenant Signature

Date

Step Up™ of Save the Family

Date

DISCLOSURE OF INFORMATION ON LEAD-BASED PAINT AND LEAD-BASED PAINT HAZARDS

LEAD WARNING STATEMENT

Housing built before 1978 may contain lead-based paint. Lead from paint, paint chips, and dust can pose a hazard if not taken care of properly. Lead exposure is especially harmful to young children and pregnant women. Before renting pre1978 housing, property owners must disclose the presence

of known lead-based paint hazards in the dwelling. Tenants must also receive a federally approved pamphlet on lead poisoning prevention.

Landlord/Agency Disclosure

Presence of lead-based paint or lead-based paint hazards (check one below):

- A. Known lead-based paint and/or lead-based paint hazards are present in the housing
- B. Agency has no known knowledge of lead-based paint and/or lead-based paint hazards in the housing.

Records and reports available to the lessor (check one below):

- A. The agency has provided the client with all available records pertaining to lead-based paint and/or lead-based paint hazards in the housing (list all documents below).
- B. Agency has no reports or records pertaining to lead-based paint and/or lead-based paint hazards in the housing.

Client/Tenant Acknowledgement (initial)

- A. Client/Tenant has received copies of all the information above.
- B. Client/Tenant has received the pamphlet Protect your Family from Lead in Your Home.

CLIENT GRIEVANCE PROCEDURE:

Purpose: To assure clients a method of resolving differences with staff members and allow them a method for expressing dissatisfaction with element(s) of the program or environment of care.

Policy: Save the Family encourages clients who are not satisfied with specific circumstances or services to file a written grievance at any time and for any reason with program staff. It is Save the Family's policy to settle these grievances in a timely and fair manner by allowing input from all concerned parties. Clients are advised of this process during the initial intake into the program by reading and an explanation of the client handbook, and reviewing the client's rights.

Definitions:

- ☐ Grievance: A Client's documented expression of dissatisfaction to Save the Family about an act, omission, or condition of Save the Family; and/or a Client's written response to a Termination Notice.
- ☐ Arbitrator: Former Save the Family Transitional Clients who volunteer to hear the grievances of current Transitional Clients and make an independent recommendation to the Agency regarding the grievance.

Procedure: Clients wishing to file a complaint/grievance regarding a Save the Family Employee, Volunteer, another Client, maintenance, housing/property, element(s) of the program, or the environment of care should complete the following steps:

- 1) Complete a Client Complaint & Grievance Form available in or near the reception area. If the Client is unsure how to complete the form, he/she may ask a staff member to help. The Client will submit the completed form to the receptionist. The receptionist will date the form, make a copy for the Client and forward the form to the Chief Programs Officer and other assigned staff.
- 2) After the form is received, the assigned Manager will either schedule a meeting with the Client or issue a written decision within 1-3 business days and will update the Client's file and the grievance log accordingly.

In the event the Client is not satisfied with the action(s) taken by the Manager or other assigned staff, he/she should, within 1-day following the decision, request a meeting with the Director of Programs or Chief Programs Officer. This meeting must take place within three business days of the request is available.

Save the Family Clients who file a complaint or assist in the investigation of a complaint to Save the Family shall not be discharged or discriminated against for this specific activity. Each Client of Save the Family will be given a copy of the Client Complaint & Grievance Procedure as a part of the Save the Family Program Agreement.

FAIR HOUSING:

Save the Family does not discriminate on the basis of race, color, religion, age, national origin, sex, disability, sexual orientation or political affiliation and makes reasonable efforts to accommodate the physically challenged upon notification.

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, Save the Family (Save the Family) prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. Save the Family must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means that if necessary, Save the Family must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that Save the Family will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy please contact: Save the Family @ 480.898.0228. Para obtener este documento en otro formato u obtener información adicional sobre esta política Save the Family @ 480.898.0228.

EXIT/TERMINATION FROM PROGRAM

A Clients participating in the Step Up to Independence™ Program may be terminated from the program under the following circumstances:

- The family notifies their Case Manager that they no longer want to be enrolled in the program within thirty days of their intended move out. This notification can be provided in writing by the participant, or the Case Manager will document this verbal report in a progress note.
- The family abandons their unit for more than five days with no evidence that they are residing there other than the presence of some personal items.
- The family fails to pay their Occupancy fees on time.
- The family refuses to engage in services with their Case Manager and/or team.
- The family violates their Occupancy Agreement.
- The family fails to engage in the Pathways to Stability program as outlined above.
- If a participant in the family tests positive for a controlled substance it could be grounds for termination from program, if there are controlled substances in the unit.
- The family violates anything in the program agreement and is not working towards self-sufficiency, including but not limited to complying with the employment and self-sufficiency requirements.
- Any violence or criminal activity or harassing behaviors occurs on the property or toward others.
- Loss of custody, for more than 50%, will result in termination due to it being a “family” program.

In all of the above cases, the family will be provided with a written notice that summarizes the services that are being terminated, the reason for the termination of services, and a date and time the services will be discontinued. Clients may grieve a termination from the program prior to exit. Grievance procedures are provided to all clients at the time of entry into the program.

Client is responsible for having all personal belongings removed from the housing unit at the time of move-out. All locks to the unit will be changed at this time. Client agrees that the Agency is not responsible for items left in the unit. Items left in the unit after the scheduled move out date/time will be forfeited and disposed of at the agency's discretion. The Agency is not required to file an eviction action to remove Client but may do so at their discretion.

SUCCESSFUL EXIT – [100% Compliance with all criteria]

- Minimum of 6 months in program
- Occupancy charges must be paid on time monthly, by the 5th of the month, in accordance with Occupancy Fee Forms.
- Participates in classes as outlined by the case management Individual Case Plan.
- Increased income from higher wage employment determined by intake budget needed for projected expense budget.
- Decreased Debt while in the program.
- Increased overall credit score
- Completed pre-post assessments while enrolled in the program and work towards individual goals outlined in individual service plan.

- Children participated in a youth related activities, including enrolled in and attending school, childcare and participate with youth coordinator services.
- The unit must be left in clean and undamaged condition.
- Family must exit to a single family dwelling, i.e. apartment, condo, home in the community.
This cannot include affordable housing programming (ARM or other low income programs).
- Family successfully completes 75% of their goals outlined in their case plan working toward self-sufficiency.

REFUNDABLE MONIES AT EXIT

Families exiting the program successfully (see above) are eligible for a refund of all Occupancy fees, Base fee (up to 12 months) and savings (less any outstanding fees). *(effective: 5/15/23)*. Client remains liable for any financial obligations and those amounts will be deducted from any potential refund.

If a family leaves unsuccessfully the agency will return only available savings accrued. No Occupancy base fees will be refunded.

When a client exits the program, the Step Up™ Case Manager, CPO, Career Services Supervisor, Youth Advocate, and a representative from accounting will meet to discuss the client and determine as a team if the Client was a successful termination from the program.

Refunds cannot be issued until move-out process is complete and may be up to 60 days.

This Occupancy and Program Agreement is a binding agreement between the parties. Any material breach may result in termination from both the program and any rights to occupy the Premises provided by this Agreement.

Agreed to this date:_____

Client Name:_____

Client Signature:_____

Agreed to this date:_____

Client Name:_____

Client Signature:_____

Agreed to this date:_____

Authorized Signor for Agency: Name:_____

Authorized Signor for Agency Signature:_____

UMOM Transitional Housing

Service Participation Agreement

Head of Household Name: _____

Unit/Room: _____ Effective Date: _____

1. Purpose

This Service Participation Agreement outlines the supportive service expectations for families participating in UMOM Transitional Housing. UMOM provides stable transitional housing for up to 24 months, paired with comprehensive, trauma-informed supportive services designed to help families achieve self-sufficiency and successfully exit homelessness. UMOM recognizes that each household has different strengths, needs, caregiving responsibilities, school schedules, employment obligations, safety considerations, and barriers contributing to housing instability. Services are designed to help you and your family obtain and maintain housing stability, increase income, improve financial stability, access community resources, improve health and well-being, and secure permanent housing. This agreement complies with Housing and Urban Development (HUD) 24 CFR 578.75(h) and subsequent Notice of Funding Opportunity requirements under which this program is funded. The purpose of this agreement is to explain what you agree to do while in the program and what UMOM agrees to do to support your family's housing stability, safety, self-sufficiency, and progress toward permanent housing. Service requirements may be adjusted, prorated, accommodated, or exempted based on household circumstances, applicable exemptions, reasonable accommodations, and applicable program policy or law.

2. Participant Responsibilities: What You Agree to Do*

A. Meet with Your Case Manager

You agree to meet weekly with your case manager. These meetings help you and your family:

- Work on your goals
- Solve problems early
- Understand your housing responsibilities and
- Keep your housing stable

Your case manager will also help with referrals, mainstream benefits, employment services, workforce training, child care, school-related supports, community resources, and other services that fit your household's needs.

B. Work on Your Housing Stability Plan

You and your case manager will create and implement a Housing Stabilization and Self-Sufficiency Plan for your household. You agree to:

- Set and take steps toward your household's goals, including housing stability, increased income, improved financial stability, improved health and wellness, self-sufficiency, and permanent housing

- Discuss strategies, action steps, target dates, and services needed to address barriers contributing to housing instability
- Discuss the services available to you, when and how often they are provided and by whom
- Select the service types you are interested in and preferences to attend (in-person, virtual, self-directed, etc.)
- Participate in 20 hours of weekly programming and services, or a prorated or adjusted schedule if you are employed, attending education or training, have caregiving responsibilities, have school-related family obligations, or are otherwise approved for an exemption, accommodation, or adjustment
- Follow up on referrals and attend appointments
- Engage in housing retention activities, if necessary
- Turn in paperwork needed for recertification or income updates and
- Tell staff when you need help or your situation changes

C. Use Supportive Services

To the best of your ability, you agree to take part in supportive services that you or the program identifies as necessary to help your family remain successful in housing, including participation in 20 hours of weekly programming and services when required by the program. Because UMOM works with families, the type, timing, and amount of required service participation may change based on household composition, caregiving responsibilities, child care or school schedules, employment, education or training, safety needs, reasonable accommodations, exemptions, and applicable program policy or law. Services may include, but are not limited to:

- Workforce development, job readiness training, resume development, employment placement assistance, education, training, or income support
- Life skills, budgeting, financial stability, benefits navigation, child care support, and community resource access
- Health care, behavioral health, substance use treatment, wellness, pet support, or optional spiritual support referrals

You will not be required to participate in disability-related services unless the purpose of the program is to provide substance use treatment, as allowed under federal regulations.

3. Program Responsibilities: What the Program Agrees To Do

A. Provide Customized Support and Case Management

UMOM will:

- Assign you a case manager who provides individualized, trauma-informed case management and service coordination
- Help you understand your lease, if applicable
- Support you in creating and implementing a Housing Stabilization and Self-Sufficiency Plan that reflects your household's goals, needs, barriers, strengths, and family responsibilities
- Connect you with community resources, mainstream benefits, workforce services, health care, behavioral health care, substance use treatment, child care, pet support, optional spiritual support, and other services you want or need

- Provide 20 hours of weekly programming and services, when required by the program, with adjustments or prorations when appropriate for family circumstances, employment, education or training, caregiving, school schedules, exemptions, accommodations, or applicable law
- Offer services through project-based, partner-delivered, or participant self-directed activities delivered on-site, off-site, virtually, or in the community
- Tailor services for you and your household based on your family's needs, strengths, goals, barriers, readiness, and progress toward permanent housing
- Provide workforce development services, including job readiness training, resume development, employment placement assistance, and access to UMOM's Homegrown Training Programs in culinary arts, warehouse operations, and facilities maintenance
- Help families access child care through the Boys & Girls Club so parents can participate in employment, education, training, and other required services
- Assist with applications for mainstream benefits such as SNAP, child care assistance, Social Security, Medicare, and disability benefits
- Coordinate referrals and services with community partners, including Phoenix Children's Hospital, Circle the City, Empact/La Frontera, Community Bridges Inc. (CBI), Community Family Services, Open Hearts, the Arizona Pet Project, and UMOM's full-time campus pastor when requested
- Maintain a weekly service availability schedule
- Document availability of services and customization through the Housing Stability Plan

What Customized Services means: A flexible bundle of project-based, partner-delivered, community-based, or self-directed services, supports, and activities selected in collaboration with each household, based on the family's goals, strengths, needs, barriers, caregiving responsibilities, safety considerations, and readiness. Customized services are designed to support self-sufficiency, economic mobility, housing stability, and a successful exit to permanent housing. Customized services may include any combination of:

- Weekly case management, service coordination, housing stabilization planning, and self-sufficiency planning
- Workforce development, job readiness, resume development, employment placement assistance, education services, and access to UMOM's Homegrown Training Programs in culinary arts, warehouse operations, and facilities maintenance
- Life skills, budgeting, financial stability, nutrition, parenting supports, childcare navigation through the Boys & Girls Club, school coordination, and household management
- Health care services, including on-site access through Phoenix Children's Hospital and Circle the City, arranged appointments, care coordination, and wellness supports
- Behavioral health or substance use treatment referrals through partners such as Empact/La Frontera, Community Bridges Inc. (CBI), Community Family Services, and Open Hearts, when appropriate and voluntary unless required by program design and compliant with 24 CFR 578.75(h)
- Peer support, mentoring, or recovery coaching
- Benefits enrollment and income-support navigation, including SNAP, child care assistance, Social Security, Medicare, disability benefits, financial counseling, and community resource access

- Community integration activities, recreational or therapeutic programming, pet support through the Arizona Pet Project, and optional spiritual support from UMOM's full-time campus pastor
- Self-directed activities, such as online classes, job search activities, community-based support group participation, volunteering, community-building activities, and work-therapy

B. Communicate Clearly

UMOM will explain rules, expectations, weekly programming requirements, available services, partner referrals, and participant rights in clear language and provide written copies of program policies.

C. Respect Your Rights

The program will:

- Treat you with respect
- Keep your information private as required by law and
- Provide a fair and accessible grievance and appeals process

4. Non-Participation in Required Services

If you do not participate in services required by the program, including weekly programming and services, or if your family circumstances make participation difficult:

- Staff will talk with you about the concern and try to understand barriers
- Staff will work with you to re-engage in a supportive way
- You will be offered the chance to request a reasonable accommodation, exemption, proration, or adjustment if you qualify
- Staff will create corrective action plans before considering discharge

If you continue to not participate in required services after UMOM has considered barriers, family circumstances, reasonable accommodations, exemptions, prorations, and adjustments, **you may lose program assistance**, following all due process, notice, appeal, and client rights procedures included in the program's policies.

This agreement **does not** replace your lease. Lease violations follow the legal process required by the landlord and local law.

5. Your Rights

Throughout your program participation you have the right to:

- Access services in a trauma-informed manner
- Reasonable accommodations
- Accept or decline disability-related services.
- Non-discrimination
- Ability to file grievances without retaliation
- Request an exemption from, proration of, or adjustment to service participation requirements if you are employed, participating in education or training, have caregiving responsibilities, have child care or school-related family obligations, are over the age of 62, have a qualifying disability

under 24 CFR 8.3, have a developmental disability under 24 CFR 578.3, or otherwise qualify under applicable program policy or law

6. Termination & Appeals

Terminations follow 24 CFR 578.91 with due process.

7. Agreement and Acknowledgement

I have read (or had explained to me) this **Service Participation Agreement**. I understand my responsibilities and the responsibilities of UMOM. I understand that UMOM Transitional Housing provides stable housing for up to 24 months and that I may be expected to participate in 20 hours of weekly programming and services unless my service participation expectations are customized, prorated, adjusted, accommodated, or exempted based on my family's circumstances, applicable accommodations, program policy, and applicable law. I may ask questions at any time.

Signatures:

Participant: _____

Date: _____

Staff: _____

Date: _____

*Except where required participation is prohibited under VAWA, VOCA, FVPSA and other applicable laws, including for individuals and families who are fleeing or attempting to flee from domestic violence, stalking, sexual assault, or human trafficking.

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

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

MARICOPA REGIONAL CONTINUUM OF CARE (COC) COORDINATION AND NON-INTERFERENCE WITH LOCAL EFFORTS TO ADVANCE PROTECTING PUBLIC SAFETY POLICY

OVERVIEW

To promote community-wide commitment to ending homelessness, as established by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, the Maricopa Regional Continuum of Care (CoC) leads with services to engage individuals experiencing homelessness. The CoC cooperates with, and does not interfere with or impede, local efforts to advance public safety, and assists first responders in providing services to individuals experiencing homelessness. The CoC complies with all local laws and maintains close partnerships with first responders to ensure a coordinated, service-first approach.

For purposes of this policy, local efforts to advance public safety include efforts to:

- Clear tents and encampments;
- Decrease the public use of illicit drugs;
- Utilize standards to address danger to self or others (e.g., involuntary commitment); and
- Share information in accordance with the Sex Offender Registration and Notification Act (SORNA).

POLICY

NON-INTERFERENCE

The CoC, its Board, its committees, and CoC-funded recipients will not take actions that interfere with or impede lawful local efforts in each of the areas listed above and will not encourage or direct others to do so. This policy does not limit the ability of the CoC or its recipients to offer housing and services to the people affected by those efforts.

ENCAMPMENTS

The CoC supports jurisdictional outreach by creating toolkits for interdepartmental coordination, so that entities such as parks departments, outreach teams, and human services offices are actively communicating with law enforcement when interfacing with people living on the streets. Mobile Coordinated Entry (CE) access points span the entire region, focus on encampments, and ensure

proactive contact with those least likely to apply for assistance, working together with local efforts to advance public safety.

ILLICIT DRUG USE

The CoC's efforts to decrease the public use of illicit drugs are set out in the CoC's Advancing Recovery and Prohibitions Against Illicit Drug Enablement Policy, which applies to all CoC-funded housing projects and is incorporated by reference into this policy.

DANGER TO SELF OR OTHERS

The CoC will not interfere with the application of standards under applicable law to address danger to self or others, including involuntary commitment, by the authorities and professionals legally responsible for making those determinations.

SORNA COMPLIANCE

CoC-funded recipients must comply with Arizona State law regarding SORNA and its implementation within the state, as well as all state laws regarding sex offenders. The CoC will not impede information sharing conducted in accordance with SORNA. Information sharing under this policy must be consistent with applicable federal, state, and local privacy and confidentiality requirements, including the HEARTH act and the Homeless Management Information System privacy and security policies.

PARTNERSHIP WITH LAW ENFORCEMENT AND FIRST RESPONDERS

The CoC Board includes a designated law enforcement seat to ensure a strong line of communication and collaboration with local agencies. The CoC supports first responders in serving individuals experiencing homelessness by maintaining consistent communication, coordinating system-level efforts, and aligning regional strategy to uphold a coordinated, service-first approach.

IMPLEMENTATION

The CoC, its Board, its committees, and CoC-funded recipients will not take actions that interfere with or impede lawful local efforts in each of the areas listed above and will not encourage or direct others to do so. This policy does not limit the ability of the CoC or its recipients to offer housing and services to the people affected by those efforts.

ATTACHMENT A. DOCUMENT VERSION HISTORY & RATIONALE

This log provides a concise record of changes to the Policy, including when updates were made, what was changed, and the rationale behind the revisions. This supports transparency, continuity, and onboarding of new leaders/staff.

VERSION HISTORY TABLE

Version	Date Approved	Section(s) Updated	Summary of Changes	Rationale / Reason for Update	Approved By
1.0	09/22/2026	All	Adopted by the Board.	Established procedures.	CoC Board.

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

1D-1. Local Competition Scoring Tool

FY 2026 NEW PSH PROJECT SCORECARD

PART A: PROJECT DESIGN AND ELIGIBILITY

Criteria		Scorer	Submission	Points
A.1	Project Eligibility	MAG Staff	Narrative	--
A.2	Project Summary	Rank & Review	Narrative	3
A.3	Population Served	Rank & Review	Narrative	3
A.4	Supportive Services	Rank & Review	Narrative	4
A.5	Services Participation Requirement	Rank & Review	Narrative	6
A.6	Client Employment Income at Exit	Rank & Review	Narrative	6
A.7	Returns to Homelessness	Rank & Review	Narrative	6
A.8	Mainstream Benefits	Rank & Review	Narrative	4
A.9	Reasonable Budget	Rank & Review	File	4
A.10	Promoting Recovery, Agreements and Commitments	Rank & Review	Narrative	3
A.11	Promoting Recovery (partnerships)	Rank & Review	Narrative	5
A.12	Promoting Recovery (on-site treatment)	Rank & Review	Narrative	3
				47

PART B: PROJECT/AGENCY EXPERIENCE

Criteria		Scorer	Submission	Points
B.1	Housing Experience	Rank & Review	Narrative	3
B.2	Partnerships	Rank & Review	Narrative	3
B.3	Financial Capacity	Rank & Review	Narrative & File	3
				9

PART C: COMMUNITY PRIORITIES

Criteria		Scorer	Submission	Points
C.1	Lived Experience	Rank & Review	Narrative	3
C.2	Data and HMIS	Rank & Review	Narrative	3
C.3	CE Participation	Rank & Review	Narrative	3
				9

PART D: INTERVIEW

Criteria		Scorer	Submission	Points
D	Interview Question(s)	Rank & Review	Interview Response	5

PART E: BONUS POINTS

Criteria		Scorer	Submission	Points
E	Substance use treatment engagement	Rank & Review	Narrative	3

Total Score: 70

Objective Criteria: 65

Objective Rating: 93%

Performance Points: 18

Performance Rating: 26%

FY 2026 NEW PSH PROJECT APPLICATION

PART A: DESIGN AND ELIGIBILITY

A.1. Project Eligibility: Please submit your draft HUD e-snaps application to demonstrate that your project operates under the CoC Project eligible costs under 24 CFR § 578.37. Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your supportive service agreement. Attach your completed Threshold Assessment Checklist.	
<u>Required Submissions:</u> Draft HUD e-snaps Application, Attachments	<u>Scoring:</u> n/a
A.2 Project Summary: Please provide a description that addresses the entire scope of the proposed project, including the type and scale of assistance to be offered (and the funding source or partnership of each). Include the number and configuration of units and describe how they fit the needs of the program participants.	
<u>Required Submissions:</u> Narrative (800-word limit)	<u>Scoring:</u> + 1 for comprehensive description of the proposed project + 1 for description of how the units fit the needs of participants + 1 for describing the type of housing and the units proposed 3 Points Total
A.3 Population Served: Please describe your agency's (or subrecipient's) experience working with the proposed population. Confirm your project will serve homeless individuals or families with a disability. Discuss if your project will prioritize specifically people over 62 years old, and/or physically or developmentally disabled people.	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 1 for comprehensive demonstration of experience with the population + 1 for confirming the project will serve homeless individuals or families with a disability +1 for prioritizing people over 62, and/or physically or developmentally disabled 3 Points Total
A.4 Supportive Services: Please describe how the project will provide and/or partner with other organizations to provide eligible supportive services and assistance that will ensure that the participants are able to successfully obtain and retain permanent housing and in a manner that fits their needs (e.g. transportation, safety planning, enhanced case management). If the agency is proposing to expand an existing PH project, it must demonstrate how they are expanding supportive services to project participants, including where appropriate, on-site supportive services.	
<u>Required Submissions:</u> Narrative (500-word limit)	<u>Scoring:</u> + 2 for describing plans to provide services to assist participants to obtain housing + 2 for describing plans to provide services to assist participants to maintain housing 4 Points Total
A.5 Services Participation Requirement: Please describe your project's approach to require project participants to participate in services by contract, occupancy agreement, or lease. Attach your supportive service agreement. Participation requirements must be in line with 24 CFR 578.75(h).	

Approved on 6/29/2026

<i>Examples of services include case management, employment assistance and job training, life skills training, and substance use disorder treatment.</i>	
<u>Required Submissions:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the approach to require participants to participate in services described above + 2 for attaching a compliant supportive services agreement + 2 for the quality of the supportive services agreement 6 Points Total
A.6 Client Employment Income at Exit: <i>Please describe how your project will help participants secure employment to increase their earned income.</i>	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing plans to increase participants' employment income at exit + 2 for describing process and experience helping participants secure employment + 2 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.7 Returns to Homelessness: <i>Please describe how your project will help participants not reenter homelessness after their successful exit from the project.</i>	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing plans to help participants not reenter homelessness after a successful project exit. + 3 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.8 Mainstream Benefits: <i>Please describe how your project will be supplemented with resources from other public or private sources and participants assisted in obtaining mainstream health, social and employment benefits (SNAP, SSI/SSDI, Medicare, Medicaid, etc.), and how the project will coordinate the provision of mainstream benefits.</i>	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing how participants are assisted to obtain mainstream benefits they are eligible for. Detail the partnerships you have established to assist participants with connection to these benefits. + 2 for describing how the project will be supplemented by other public or private sources, which public and private sources and projected amounts 4 Points Total
A.9 Reasonable Budget: <i>Please submit a completed HUD 2026 Project Budget Workbook (located under Documents at maricopacoc.org/fy26-coc-nofo) that matches the summary budget in Question 6J of the draft HUD e-snaps application that demonstrates the average cost per household served for the project is reasonable.</i>	
<u>Required Submission:</u> Budget Chart Form	<u>Scoring:</u> + 2 for completeness and accuracy of the budget + 2 for reasonableness of cost per household served 4 Points Total
A.10 Promoting Recovery, Agreements and Commitments: <i>Please describe your project's approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs on the property. Confirm the project will not operate drug</i>	

injection sites or “safe consumption sites,” knowingly distribute drug paraphernalia on or off of property under your control, permit the use or distribution of illicit drugs on property under your control, or conduct, permit, encourage or allow any of these activities under the pretext of “harm reduction.” This is not a requirement to condition assistance on sobriety or treatment. Acknowledge and certify you will not engage in illegal racial discrimination.

Required Submission:

Narrative (300-word limit)

Scoring:

+ 1 for project’s agreement to not operate the above stated sites, and not distribute or permit the use or distribution of illicit drugs on the property under your control
 + 1 for project’s commitment to recovery
 + 1 for your acknowledgement and certification you will not engage in illegal racial discrimination

3 Points Total

A.11 Promoting Recovery:

- Identify any partnerships you have with providers and entities 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.
- Describe how the project identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as ACT teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment.
- Describe any partnerships you have with providers of 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.
- Describe how you partner with or provide access to peer recovery specialists or other forms of peer support and recovery navigation.
- Identify any partnerships you have with a Certified Community Behavioral Health Clinic (CCBHC) or Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GHBI) provider, or a similar facility;

Required Submission:

Narrative (500-word limit)

Scoring:

+ 1 for partnerships in connection with Drug Courts, specialty courts, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment.
 + 1 for describing how you identify individuals experiencing SMI and connect them with the services they need
 + 1 for describing partnerships with providers of outpatient treatment for mental health and substance use disorders
 + 1 for describing the partnership with or provide access to peer recovery specialists
 + 1 for describing the partnership with a CCBHC, CMHC, PATH provider, GHBI provider, or a similar facility

5 Points Total

A.12 Promoting Recovery: Please describe your project’s availability of on-site substance use treatment and if so, the partnership you have with a treatment provider.

Required Submission:

Narrative (300-word limit)

Scoring:

+ 2 for project’s availability of on-site substance use treatment
 + 1 for describing the partnership and naming the treatment provider

3 Points Total

PART B: EXPERIENCE

B.1 Housing Experience: Please describe your agency's (or subrecipient's) experience in providing housing similar to the intervention proposed in the application. If you do not have experience with the intervention, explain how you will supplement the lack of experience through partnerships.		
Required Submission: Narrative (300-word limit)	Scoring: + 3 for comprehensive demonstration of experience 3 Points Total	
B.2 Partnerships: Please describe your project's approach integrating healthcare, faith-based and other partnership types into the provision of services and housing (e.g. partnerships with primary healthcare, on-site and off-site substance use disorder treatment, mental health treatment, workforce development, faith-based and other partnership types) and the additional resources (\$s) these partnerships bring to the project (demonstrate the commitment of at least 25% match). Attach MOUs/agreements to demonstrate these partnerships.		
Required Submission: Narrative (300-word limit)	Scoring: + 1 for describing the agency's approach and experience partnering with the entities described above + 2 for describing the resources (\$s and % of project budget, minimum 25%) these partnerships bring to the project including MOUs/ agreements to demonstrate these partnerships 3 Points Total	
B.3 Financial Capacity: Please submit your agency's most recent financial audit and management letter or internal audit (if no financial audit is available) OR provide an explanation as to why there has not been an audit. If your audit indicates any findings or concerns, please provide documentation that those findings have been resolved, or the agency has attempted to resolve them. Describe your experience with other federal funding sources. Describe your ability to manage federal compliance requirements, including 2 CFR 200 and 24 CFR 578 (provide examples of good standing on external monitoring).		
Required Submission: Financial audit or internal audit and management letter; documentation of resolution or attempts to resolve Narrative (300-word limit)	Scoring (w/ Findings): + 1 steps taken to resolve findings from most recent audit or internal audit + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total	Scoring (No Findings): + 1 for audit with no findings + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total

PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: Describe how your agency takes proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.	
Required Submissions: Narrative (300-word limit) Documentation	Scoring: + 2 for lived experience membership on boards or committees + 1 for incorporating lived experience in project design 3 Points Total
C.2 Data and HMIS: Please describe your agency's knowledge of the HMIS. Please explain the project's commitment to collecting accurate data, reviewing it to evaluate participant outcomes and upholding required HMIS data quality standards.	

<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for knowledge, or active involvement, with the Maricopa HMIS + 1 for describing the project data evaluation and review approach + 1 for upholding required HMIS data quality standards 3 Points Total
<i>C.3 Coordinated Entry (CE) Participation:</i> Please describe your agency's knowledge of the Coordinated Entry. Then, explain the project's commitment to ensuring 100% of people enrolled are referred through the Family and/or the Singles Coordinated Entry System.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for knowledge, or active involvement, with Coordinated Entry + 1 for describing how you will ensure 100% participant enrollment through the CES 3 Points Total

PART D: INTERVIEW

This section will be conducted with the Rank & Review Committee following the submission of your application. The questions to be asked will be selected by the CoC Board and distributed prior to your interview.

PART E: BONUS POINTS

Bonus points may be awarded based on the criteria below. However, bonus points cannot increase an application's final score above the maximum Total Score established for this application.

<i>E.1 Substance use treatment engagement:</i> Bonus points are awarded if CoC-funded units require participant engagement in substance use treatment services as a condition of continued participation. Please state your level of commitment to participants' required engagement in substance use treatment services as a condition of continued program participation.	
<u>Required Submissions:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 100% of the units require participant engagement + 2 At least 50% of the units require participant engagement 3 Points Max

FY 2026 NEW RRH PROJECT SCORECARD

PART A: PROJECT DESIGN AND ELIGIBILITY

Criteria		Scorer	Submission	Points
A.1	Project Eligibility	MAG Staff	Narrative	--
A.2	Project Summary	Rank & Review	Narrative	3
A.3	Population Served	Rank & Review	Narrative	3
A.4	Supportive Services	Rank & Review	Narrative	4
A.5	Services Participation Requirement	Rank & Review	Narrative	6
A.6	Client Employment Income at Exit	Rank & Review	Narrative	6
A.7	Returns to Homelessness	Rank & Review	Narrative	6
A.8	Mainstream Benefits	Rank & Review	Narrative	4
A.9	Reasonable Budget	Rank & Review	File	4
A.10	Promoting Recovery, Agreements and Commitments	Rank & Review	Narrative	3
A.11	Promoting Recovery (partnerships)	Rank & Review	Narrative	5
A.12	Promoting Recovery (on-site treatment)	Rank & Review	Narrative	3
				47

PART B: PROJECT/AGENCY EXPERIENCE

Criteria		Scorer	Submission	Points
B.1	Housing Experience	Rank & Review	Narrative	3
B.2	Partnerships	Rank & Review	Narrative	3
B.3	Financial Capacity	Rank & Review	Narrative & File	3
				9

PART C: COMMUNITY PRIORITIES

Criteria		Scorer	Submission	Points
C.1	Lived Experience	Rank & Review	Narrative	3
C.2	Data and HMIS	Rank & Review	Narrative	3
C.3	CE Participation	Rank & Review	Narrative	3
				9

PART D: INTERVIEW

Criteria		Scorer	Submission	Points
D	Interview Question(s)	Rank & Review	Interview Response	5

PART E: BONUS POINTS

Criteria		Scorer	Submission	Points
E	Substance use treatment engagement	Rank & Review	Narrative	3

Total Score: 70

Objective Criteria: 65

Objective Rating: 93%

Performance Points: 18

Performance Rating: 26%

FY 2026 NEW RRH PROJECT APPLICATION

PART A: DESIGN AND ELIGIBILITY

A.1. Project Eligibility: Please submit your draft HUD e-snaps application to demonstrate that your project operates under the CoC Project eligible costs under 24 CFR § 578.37. Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your supportive service agreement. Attach your completed Threshold Assessment Checklist.	
<u>Required Submissions:</u> Draft HUD e-snaps Application, Attachments	<u>Scoring:</u> n/a
A.2 Project Summary: Please provide a description that addresses the entire scope of the proposed project, including the type and scale of all assistance to be offered (and the funding source or partnership of each). Describe how the provision of tenant-based rental assistance will help individuals and families achieve self-sufficiency within 24 months.	
<u>Required Submissions:</u> Narrative (800-word limit)	<u>Scoring:</u> + 1 for comprehensive description of the proposed project + 2 for describing how the provision of rental assistance will help participants achieve self-sufficiency within 24 months 3 Points Total
A.3 Population Served: Please describe your agency's (or subrecipient's) experience working with the proposed population. Please describe your experience or plans to have at least 50 percent of participants exit to permanent housing within 24 months and at least 50 percent of participants exit with employment income.	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 1 for comprehensive demonstration of experience with the population + 1 experience or plans to have at least 50 percent of participants exit to permanent housing within 24 months + 1 experience or plans to have at least 50 percent of participants exit with employment income. 3 Points Total
A.4 Supportive Services: Please describe how the project will provide and/or partner with other organizations to provide eligible supportive services and assistance that will ensure that the participants are able to successfully obtain self-sufficiency and exit homelessness (e.g. case management, substance use treatment, mental health treatment, and employment assistance). If the agency is proposing to expand an existing PH project, it must demonstrate how they are expanding supportive services to project participants.	
<u>Required Submissions:</u> Narrative (500-word limit)	<u>Scoring:</u> + 2 for describing plans to provide services to assist participants to obtain self-sufficiency + 2 for describing plans to provide services to assist participants to successfully exit homelessness 4 Points Total
A.5 Services Participation Requirement: Please describe your project's approach to require project participants to participate in services by contract, occupancy agreement, or lease. Attach your supportive service agreement. Participation requirements must be in line with 24 CFR 578.75(h). Examples of services include case management, employment assistance and job training, life skills training, and substance abuse treatment.	

Approved on 6/29/2026

<u>Required Submissions:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the approach to require participants to participate in services described above + 2 for attaching a compliant supportive services agreement + 2 for the quality of the supportive services agreement 6 Points Total
A.6 Client Employment Income at Exit: Please describe how your project will help participants secure employment to increase their earned income.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing plans to increase participants' employment income at exit + 2 for describing process and experience helping participants secure employment + 2 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.7 Returns to Homelessness: Please describe how your project will help participants not reenter homelessness after their successful exit from the project.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing plans to help participants not reenter homelessness after project exit. + 3 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.8 Mainstream Benefits: Please describe how your project will be supplemented with resources from other public or private sources and participants assisted in obtaining mainstream health, social and employment benefits (SNAP, SSI/SSDI, Medicare, Medicaid, etc.), and how the project will coordinate the provision of mainstream benefits.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing how participants are assisted to obtain mainstream benefits they are eligible for. Detail the partnerships you have established to assist participants with connection to these benefits. + 2 for describing how the project will be supplemented by other public or private sources, which public and private sources and projected amounts 4 Points Total
A.9 Reasonable Budget: Please submit a completed HUD 2026 Project Budget Workbook (located under Documents at maricopacoc.org/fy26-coc-nofo) that matches the summary budget in Question 6J of the draft HUD e-snaps application that demonstrated the average cost per household served for the project is reasonable.	
<u>Required Submission:</u> Budget Chart Form	<u>Scoring:</u> + 2 for completeness and accuracy of the budget + 2 for reasonableness of cost per household served 4 Points Total
A.10 Promoting Recovery, Agreements and Commitments: Please describe your project's approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs on the property. Confirm the project will not operate drug injection sites or "safe consumption sites," knowingly distribute drug paraphernalia on or off of property under your control, permit the use or distribution of illicit drugs on property under your	

control, or conduct, permit, encourage or allow any of these activities under the pretext of “harm reduction.” This is not a requirement to condition assistance on sobriety or treatment. Acknowledge and certify you will not engage in illegal racial discrimination.

Required Submission:

Narrative (300-word limit)

Scoring:

- + 1 for project’s agreement to not operate the above stated sites, and not distribute or permit the use or distribution of illicit drugs on the property under your control
- + 1 for project’s commitment to recovery
- + 1 for your acknowledgement and certification you will not engage in illegal racial discrimination

3 Points Total

A.11 Promoting Recovery:

- Identify any partnerships you have with providers and entities 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.
- Describe how the project identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as ACT teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment.
- Describe any partnerships you have with providers of 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.
- Describe how you partner with or provide access to peer recovery specialists or other forms of peer support and recovery navigation.
- Identify any partnerships you have with a Certified Community Behavioral Health Clinic (CCBHC) or Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GHBI) provider, or a similar facility;

Required Submission:

Narrative (500-word limit)

Scoring:

- + 1 for partnerships in connection with Drug Courts, specialty courts, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment.
- + 1 for describing how you identify individuals experiencing SMI and connect them with the services they need
- + 1 for describing partnerships with providers of outpatient treatment for mental health and substance use disorders
- + 1 for describing the partnership with or provide access to peer recovery specialists
- + 1 for describing the partnership with a CCBHC, CMHC, PATH provider, GHBI provider, or a similar facility

5 Points Total

A.12 Promoting Recovery: Please describe your project’s availability of on-site substance use treatment and if so, the partnership you have with a treatment provider.

Required Submission:

Narrative (300-word limit)

Scoring:

- + 2 for project’s availability of on-site substance use treatment
- + 1 for describing the partnership and naming the treatment provider

3 Points Total

PART B: EXPERIENCE

B.1 Housing Experience: Please describe your agency's (or subrecipient's) experience in providing housing similar to the intervention proposed in the application. If you do not have experience with the intervention, explain how you will supplement the lack of experience through partnerships.		
Required Submission: Narrative (300-word limit)	Scoring: + 3 for comprehensive demonstration of experience 3 Points Total	
B.2 Partnerships: Please describe your project's approach integrating healthcare, faith-based and other partnership types into the provision of services and housing (e.g. partnerships with primary healthcare, on-site and off-site substance use disorder treatment, mental health treatment, workforce development, faith-based and other partnership types) and the additional resources (\$s) these partnerships bring to the project (demonstrate the commitment of at least 25% match). Attach MOUs/agreements to demonstrate these partnerships.		
Required Submission: Narrative (300-word limit)	Scoring: + 1 for describing the agency's approach and experience partnering with the entities described above + 2 for describing the resources (\$s and % of project budget, minimum 25%) these partnerships bring to the project including MOUs/ agreements to demonstrate these partnerships 3 Points Total	
B.3 Financial Capacity: Please submit your agency's most recent financial audit and management letter or internal audit (if no financial audit is available) OR provide an explanation as to why there has not been an audit. If your audit indicates any findings or concerns, please provide documentation that those findings have been resolved, or the agency has attempted to resolve them. Describe your experience with other federal funding sources. Describe your ability to manage federal compliance requirements, including 2 CFR 200 and 24 CFR 578 (provide examples of good standing on external monitoring).		
Required Submission: Financial audit or internal audit and management letter; documentation of resolution or attempts to resolve Narrative (300-word limit)	Scoring (w/ Findings): + 1 steps taken to resolve findings from most recent audit or internal audit + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total	Scoring (No Findings): + 1 for audit with no findings + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total

PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: Describe how your agency takes proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.	
Required Submissions: Narrative (300-word limit) Documentation	Scoring: + 2 for lived experience membership on boards or committees + 1 for incorporating lived experience in project design 3 Points Total
C.2 Data and HMIS: Please describe your agency's knowledge of the HMIS. Please explain the project's commitment to collecting accurate data, reviewing it to evaluate participant outcomes and upholding required HMIS data quality standards.	

<u>Required Submission:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 1 for knowledge, or active involvement, with the Maricopa HMIS + 1 for describing the project data evaluation and review approach + 1 for upholding required HMIS data quality standards 3 Points Total
<i>C.3 Coordinated Entry (CE) Participation:</i> Please describe your agency's knowledge of the Coordinated Entry. Then, explain the project's commitment to ensuring 100% of people enrolled are referred through the Family and/or the Singles Coordinated Entry System.	
<u>Required Submission:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 2 for knowledge, or active involvement, with Coordinated Entry + 1 for describing how you will ensure 100% participant enrollment through the CES 3 Points Total

PART D: INTERVIEW

This section will be conducted with the Rank & Review Committee following the submission of your application. The questions to be asked will be selected by the CoC Board and distributed prior to your interview.

PART E: BONUS POINTS

Bonus points may be awarded based on the criteria below. However, bonus points cannot increase an application's final score above the maximum Total Score established for this application.

<i>E.1 Substance use treatment engagement:</i> Bonus points are awarded if CoC-funded units require participant engagement in substance use treatment services as a condition of continued participation. Please state your level of commitment to participants' required engagement in substance use treatment services as a condition of continued program participation.	
<u>Required Submissions:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 3 100% of the units require participant engagement + 2 At least 50% of the units require participant engagement 3 Points Max

**FY 2026 NEW SUPPORTIVE SERVICES ONLY (SSO) COORDINATED ENTRY PROJECT
SCORECARD**

(EXCEPT SSO OUTREACH, STANDALONE AND HMIS)

PART A: PROJECT DESIGN AND ELIGIBILITY

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
A.1	Project Eligibility	MAG Staff	Narrative	--
A.2	Project Summary	Rank & Review	Narrative	3
A.3	CE Accessibility	Rank & Review	Narrative	5
A.4	CE Advertising	Rank & Review	Narrative	4
A.5	CE Referrals	Rank & Review	Narrative	4
A.6	Diversion Rate	Rank & Review	Narrative	6
A.7	Assessment Rate	Rank & Review	Narrative	6
A.8	Returns to Homelessness	Rank & Review	Narrative	6
A.9	Reasonable Budget	Rank & Review	File	4
A.10	Promoting Recovery, Agreements and Commitments	Rank & Review	Narrative	3
A.11	Promoting Recovery (partnerships)	Rank & Review	Narrative	5
				46

PART B: PROJECT/AGENCY EXPERIENCE

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
B.1	Experience with Services	Rank & Review	Narrative	4
B.2	Partnerships	Rank & Review	Narrative	3
B.3	Financial Capacity	Rank & Review	Narrative & File	3
				10

PART C: COMMUNITY PRIORITIES

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
C.1	Lived Experience	Rank & Review	Narrative	3
C.2	Data and HMIS	Rank & Review	Narrative	3
C.3	CE Participation	Rank & Review	Narrative	3
				9

PART D: INTERVIEW

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
D	Interview Question(s)	Rank & Review	Interview Response	5

Total Score: 70

Objective Criteria: 65

Objective Rating: 93%

Performance Points: 18

Performance Rating: 26%

FY 2026 NEW SSO COORDINATED ENTRY PROJECT APPLICATION

PART A: DESIGN AND ELIGIBILITY

A.1 Project Eligibility: Please submit your draft HUD e-snaps application to demonstrate that your project operates under the CoC Project eligible costs under 24 CFR § 578.37 . Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your completed Threshold Assessment Checklist.	
<u>Required Submissions:</u> Draft HUD e-snaps Application, Attachments	<u>Scoring:</u> n/a
A.2 Project Summary: Please provide a description that addresses the entire scope of the proposed project, including the type and scale of all assistance to be offered (and the funding source or partnership of each).	
<u>Required Submissions:</u> Narrative (800-word limit)	<u>Scoring:</u> + 1 for comprehensive description of the proposed project + 2 for describing the type and scale of all assistance to be offered 3 Points Total
A.3 CE Accessibility: Describe the CE's availability for all persons within the CoC's geographic area who are seeking homelessness assistance. Describe how the CE is easily available and reachable by all persons. Describe how the CE is accessible for persons with disabilities within the CoC's geographic area.	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 1 for describing the CE's availability for all persons + 2 for describing how the CE is available and reachable by all persons + 2 for describing how the CE is accessible for persons with disabilities 5 Points Total
A.4 CE Advertising: Please describe your project's strategy for advertising that is designed specifically to reach households experiencing homelessness with the highest needs.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the project's advertising strategy + 2 for describing how the advertising strategy is designed specifically to reach households experiencing homelessness with the highest needs. 4 Points Total
A.5 CE Referrals: Please describe how your project will ensure program participants are directed to appropriate housing and services that fit their needs.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing how your project will ensure program participants are directed to appropriate housing that fit their needs + 2 for describing how your project will ensure program participants are directed to appropriate services that fit their needs 4 Points Total

A.6 Diversion Rate: Please describe how your project will help participants not become homeless by successfully diverting them from entering a crisis response program.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing diversion plans to help participants not become homeless. + 3 for describing plans on how to meet or exceed current performance standard for the metric (if there is no set performance standard, project the estimated diversion rate you will achieve) 6 Points Total
A.7 Assessment Rate: Please describe how your project will help participants receive a timely, standardized, comprehensive and accurate housing needs assessment. Please describe the project's standardized assessment process.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing the standardized assessment process and plans to help participants receive a timely, comprehensive and accurate housing needs assessment. + 3 for describing plans on how to meet or exceed current performance standard for the metric (if there is no set performance standard, project the estimated assessment rate you will achieve for the eligible population(s) served) 6 Points Total
A.8 Returns to Homelessness: Please describe how your project will help participants not reenter homelessness after their successful referral and placement in a housing project.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing plans to help participants not reenter homelessness after a successful referral and placement in a housing project. + 3 for describing plans on how to meet or exceed current performance standard for the metric (if there is no set performance standard, project the estimated return to homelessness rate for the eligible population(s) served – the population successfully referred and placed in housing projects) 6 Points Total
A.9 Reasonable Budget: Please submit a completed HUD 2026 Project Budget Workbook (located under Documents at maricopacoc.org/fy26-coc-nofo) that matches the summary budget in Question 6J of the draft HUD e-snaps application that demonstrated the average cost per household served for the project is reasonable.	
<u>Required Submission:</u> Budget Chart Form	<u>Scoring:</u> + 2 for completeness and accuracy of the budget + 2 for reasonableness of costs per household served 4 Points Total
A.10 Promoting Recovery, Agreements and Commitments: Please describe your project's approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs. Confirm the project will not operate drug injection sites or "safe consumption sites," knowingly distribute drug paraphernalia, or conduct, permit, encourage or allow any of these activities under the pretext of "harm reduction." This is not a requirement to condition assistance on sobriety or treatment. Acknowledge and certify you will not engage in illegal racial discrimination.	

<u>Required Submission:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 1 for project's agreement to not distribute or permit the use or distribution of illicit drugs or drug paraphernalia part of the program + 1 for project's commitment to recovery + 1 for your acknowledgement and certification you will not engage in illegal racial discrimination 3 Points Total
A.11 Promoting Recovery: • <i>Identify any partnerships you have with providers and entities 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.</i> • <i>Describe how the project identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as ACT teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment.</i> • <i>Describe any partnerships you have with providers of 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.</i> • <i>Describe how you partner with or provide access to peer recovery specialists or other forms of peer support and recovery navigation.</i> • <i>Identify any partnerships you have with a Certified Community Behavioral Health Clinic (CCBHC) or Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GHBI) provider, or a similar facility;</i>	
<u>Required Submission:</u> <i>Narrative (500-word limit)</i>	<u>Scoring:</u> + 1 for partnerships in connection with Drug Courts, specialty courts, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment. + 1 for describing how you identify individuals experiencing SMI and connect them with the services they need + 1 for describing partnerships with providers of outpatient treatment for mental health and substance use disorders + 1 for describing the partnership with or provide access to peer recovery specialists + 1 for describing the partnership with a CCBHC, CMHC, PATH provider, GHBI provider, or a similar facility 5 Points Total

PART B: EXPERIENCE

B.1 Experience with Services: <i>Describe the experience of your agency and your subrecipients (if any) in providing services similar to those proposed in the application. If you and your subrecipients (if any) do not have experience providing similar services, explain how you will supplement the lack of experience through partnership with other organizations.</i>	
<u>Required Submission:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 2 for describing the successful work connecting people with services and housing they need

	+ 2 for describing the experience or partnerships providing supportive services	
	4 Points Total	
B.2 Partnerships: Please describe your project’s approach integrating healthcare, faith-based and other partnership types into the provision of services and engagement (e.g., partnerships with primary healthcare, substance use disorder treatment, mental health treatment, workforce development, faith-based and other partnership types) and the additional resources (\$s) these partnerships bring to the project (demonstrate the commitment of at least 25% match). Attach MOUs/agreements to demonstrate these partnerships.		
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for describing the agency’s approach and experience partnering with the entities described above + 2 for describing the resources (\$s and % of project budget, minimum 25%) these partnerships bring to the project including MOUs/ agreements to demonstrate these partnerships	
	3 Points Total	
B.3 Financial Capacity: Please submit your agency’s most recent financial audit and management letter or internal audit (if no financial audit is available) OR provide an explanation as to why there has not been an audit. If your audit indicates any findings or concerns, please provide documentation that those findings have been resolved, or the agency has attempted to resolve them. Describe your experience with other federal funding sources. Describe your ability to manage federal compliance requirements, including 2 CFR 200 and 24 CFR 578 (provide examples of good standing on external monitoring).		
<u>Required Submission:</u> Financial audit or internal audit and management letter; documentation of resolution or attempts to resolve Narrative (300-word limit)	<u>Scoring (w/ Findings):</u> + 1 steps taken to resolve findings from most recent audit or internal audit + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements	<u>Scoring (No Findings):</u> + 1 for audit with no findings + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements
	3 Points Total	3 Points Total

PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: Describe how your agency will take proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.	
<u>Required Submissions:</u> Narrative (300-word limit) Documentation	<u>Scoring:</u> + 2 for lived experience membership on boards or committees + 1 for incorporating lived experience in project design 3 Points Total
C.2 Data and HMIS: Please describe your agency's knowledge of the HMIS. Please explain the project's commitment to collecting accurate data, reviewing it to evaluate participant outcomes and upholding required HMIS data quality standards.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for knowledge, or active involvement, with the Maricopa HMIS

	+ 1 for describing the project's data evaluation and review + 1 for upholding required HMIS data quality standards 3 Points Total
C.3 Coordinated Entry (CE) Participation: <i>Please describe your agency's knowledge of Coordinated Entry. Then, explain the project's commitment to ensuring 100% of people accessing the CE will be enrolled and receive a timely assessment.</i>	
<u>Required Submission:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 2 for knowledge, or active involvement, with Coordinated Entry + 1 for describing how 100% of participants contacting the CE will be enrolled and <i>receive a timely assessment</i> 3 Points Total

PART D: INTERVIEW

This section will be conducted with the Rank & Review Committee following the submission of your application. The questions to be asked will be selected by the CoC Board and distributed prior to your interview.

**FY 2026 NEW SUPPORTIVE SERVICES ONLY (SSO) OUTREACH PROJECT SCORECARD
(EXCEPT CE, STANDALONE AND HMIS)**

PART A: PROJECT DESIGN AND ELIGIBILITY

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
A.1	Project Eligibility	MAG Staff	Narrative	--
A.2	Project Summary	Rank & Review	Narrative	3
A.3	Supportive Services	Rank & Review	Narrative	5
A.4	Client Employment Income at Exit	Rank & Review	Narrative	6
A.5	Returns to Homelessness	Rank & Review	Narrative	6
A.6	Services Participation Requirement	Rank & Review	Narrative	6
A.7	Mainstream Benefits	Rank & Review	Narrative	4
A.8	Reasonable Budget	Rank & Review	File	4
A.9	Promoting Recovery, Agreements and Commitments	Rank & Review	Narrative	3
A.10	Promoting Recovery (partnerships)	Rank & Review	Narrative	5
				42

PART B: PROJECT/AGENCY EXPERIENCE

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
B.1	Experience with Outreach and Connections to Housing, Shelter, or Transitional Housing	Rank & Review	Narrative	4
B.2	Partnerships with First Responders & Law Enforcement	Rank & Review	Narrative	4
B.3	Partnerships	Rank & Review	Narrative	3
B.4	Financial Capacity	Rank & Review	Narrative & File	3
				14

PART C: COMMUNITY PRIORITIES

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
C.1	Lived Experience	Rank & Review	Narrative	3
C.2	Data and HMIS	Rank & Review	Narrative	3
C.3	CE Participation	Rank & Review	Narrative	3
				9

PART D: INTERVIEW

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
D	Interview Question(s)	Rank & Review	Interview Response	5

Total Score: 70

Objective Criteria: 65

Objective Rating: 93%

Performance Points: 18

Performance Rating: 26%

FY 2026 NEW SSO OUTREACH PROJECT APPLICATION

PART A: DESIGN AND ELIGIBILITY

A.1 Project Eligibility: Please submit your draft HUD e-snaps application to demonstrate that your project operates under the CoC Project eligible costs under 24 CFR § 578.37. Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your supportive service agreement. Attach your completed Threshold Assessment Checklist.	
<u>Required Submissions:</u> Draft HUD e-snaps Application, Attachments	<u>Scoring:</u> n/a
A.2 Project Summary: Please provide a description that addresses the entire scope of the proposed project, including the type and scale of all assistance to be offered (and the funding source or partnership of each).	
<u>Required Submissions:</u> Narrative (800-word limit)	<u>Scoring:</u> + 1 for comprehensive description of the proposed project + 2 for describing the type and scale of all assistance to be offered 3 Points Total
A.3 Supportive Services: Describe the experience of your agency and your subrecipients (if any) in providing supportive services similar to that proposed in the application. Specifically address your agency and subrecipients strategy for providing supportive services to participants with histories of unsheltered homelessness and those who do not traditionally engage with supportive services. If you and your subrecipients (if any) do not have experience providing similar supportive services, explain how you will supplement the lack of experience through partnership with other organizations.	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 3 for describing the strategy for providing services for unsheltered homeless participants who do not traditionally engage + 2 for demonstration of experience with the type of supportive services proposed to be offered 5 Points Total
A.4 Client Employment Income at Exit: Please describe how your project will help participants secure employment to increase their earned income. This may include the process for developing client service plans for income-related services, or descriptions of services offered.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing plans for developing client service plans for income-related services + 2 for describing the process and experience helping participants secure employment + 2 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.5 Returns to Homelessness: Please describe how your project will help participants not reenter homelessness after their successful exit from the project.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing plans to help participants not reenter homelessness after a successful project exit.

Approved on 6/29/2026

	+ 3 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.6 Services Participation Requirement: Please describe your project’s approach requiring project participants participate in services by contract. Attach your supportive service agreement. Participation requirements must be in line with 24 CFR 578.75(h). Examples of services include case management, employment assistance and job training, life skills training, and substance abuse treatment.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the approach to require participants to participate in services described above + 2 for attaching the supportive services agreement + 2 for the quality of the supportive services agreement 6 Points Total
A.7 Mainstream Benefits: Please describe how your project will be supplemented with resources from other public or private sources and participants assisted in obtaining mainstream health, social and employment benefits (SNAP, SSI/SSDI, Medicare, Medicaid, etc.), and how the project will coordinate the provision of mainstream benefits.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing how participants are assisted to obtain mainstream benefits they are eligible for. Detail the partnerships you have established to assist participants with connection to these benefits. + 2 for describing how the project will be supplemented by other public or private sources, which public and private sources and projected amounts 4 Points Total
A.8 Reasonable Budget: Please submit a completed HUD 2026 Project Budget Workbook (located under Documents at maricopacoc.org/fy26-coc-nofo) that matches the summary budget in Question 6J of the draft HUD e-snaps application that demonstrated the average cost per household served for the project is reasonable.	
<u>Required Submission:</u> Budget Chart Form	<u>Scoring:</u> + 2 for completeness and accuracy of the budget + 2 for reasonableness of costs per household served 4 Points Total
A.9 Promoting Recovery, Agreements and Commitments: Please describe your project’s approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs. Confirm the project will not operate drug injection sites or “safe consumption sites,” knowingly distribute drug paraphernalia, or conduct, permit, encourage or allow any of these activities under the pretext of “harm reduction.” This is not a requirement to condition assistance on sobriety or treatment. Acknowledge and certify you will not engage in illegal racial discrimination.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for project’s agreement to not distribute or permit the use or distribution of illicit drugs or drug paraphernalia part of the program + 1 for project’s commitment to recovery + 1 for your acknowledgement and certification you will not engage in illegal racial discrimination

3 Points Total	
A.10 Promoting Recovery: - Identify any partnerships you have with providers and entities 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. - Describe how the project identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as ACT teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment. - Describe any partnerships you have with providers of 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. - Describe how you partner with or provide access to peer recovery specialists or other forms of peer support and recovery navigation. - Identify any partnerships you have with a Certified Community Behavioral Health Clinic (CCBHC) or Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GHBI) provider, or a similar facility;	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 1 for partnerships in connection with Drug Courts, specialty courts, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment. + 1 for describing how you identify individuals experiencing SMI and connect them with the services they need + 1 for describing partnerships with providers of outpatient treatment for mental health and substance use disorders + 1 for describing the partnership with or provide access to peer recovery specialists + 1 for describing the partnership with a CCBHC, CMHC, PATH provider, GHBI provider, or a similar facility 5 Points Total

PART B: EXPERIENCE

B.1 Experience with Outreach and Connections to Housing, Shelter, or Transitional Housing: Describe your agency's experience in providing outreach services or a plan for providing outreach services consistent with the activity description at 24 CFR 578.53(e)(13). Describe your effectiveness at helping people successfully exit from places not meant for human habitation to emergency shelter, treatment projects, transitional housing or permanent housing projects.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the successful work connecting people with shelter and housing resources + 2 for describing the experience or partnerships providing outreach services 4 Points Total
B.2 Partnerships with First Responders and Law Enforcement: Please describe your agency's experience building partnerships or a plan for partnering with first responders and law enforcement. Demonstrate that you have a history of or that you will partner with first responders and law enforcement to engage people living in places not meant for human habitation to access emergency	

shelter, treatment projects, reunification with family, transitional housing or independent living. Confirm that you will cooperate, and not interfere or impede with the enforcement of local laws such as public camping and public drug use laws and assist/be willing to assist first responders in their efforts to engage homeless individuals.

<u>Required Submission:</u> Narrative (300-word limit)	+ 1 for describing the agency's experience or plan to partner with the entities described above + 2 for describing of agency's experience partnering or commitment to partner with first responders and law enforcement to engage unsheltered participants + 1 for confirming that your agency will cooperate, assist/be willing to assist, and not interfere or impede law enforcement 4 Points Total
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B.3 Partnerships: Please describe your project's approach integrating healthcare, faith-based and other partnership types into the provision of services and engagement (e.g., partnerships with primary healthcare, substance use disorder treatment, mental health treatment, workforce development, faith-based and other partnership types) and the additional resources (\$s) these partnerships bring to the project (demonstrate the commitment of at least 25% match). Attach MOUs/agreements to demonstrate these partnerships.

<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for describing the agency's approach and experience partnering with the entities described above + 2 for describing the resources (\$s and % of project budget, minimum 25%) these partnerships bring to the project including MOUs/ agreements to demonstrate these partnerships 3 Points Total
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B.4 Financial Capacity: Please submit your agency's most recent financial audit and management letter or internal audit (if no financial audit is available) OR provide an explanation as to why there has not been an audit. If your audit indicates any findings or concerns, please provide documentation that those findings have been resolved, or the agency has attempted to resolve them. Describe your experience with other federal funding sources. Describe your ability to manage federal compliance requirements, including 2 CFR 200 and 24 CFR 578 (provide examples of good standing on external monitoring).

<u>Required Submission:</u> Financial audit or internal audit and management letter; documentation of resolution or attempts to resolve Narrative (300-word limit)	<u>Scoring (w/ Findings):</u> + 1 steps taken to resolve findings from most recent audit or internal audit + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total	<u>Scoring (No Findings):</u> + 1 for audit with no findings + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total
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PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: Describe how your agency will take proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.

<u>Required Submissions:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for lived experience membership on boards or committees
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Approved on 6/29/2026

<i>Documentation</i>	+ 1 for incorporating lived experience in project design 3 Points Total
C.2 Data and HMIS: Please describe your agency's knowledge of the HMIS. Please explain the project's commitment to collecting accurate data, reviewing it to evaluate participant outcomes and upholding required HMIS data quality standards.	
<u>Required Submission:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 1 for knowledge, or active involvement, with the Maricopa HMIS + 1 for describing the project's data evaluation and review + 1 for upholding required HMIS data quality standards 3 Points Total
C.3 Coordinated Entry (CE) Participation: Please describe your agency's knowledge of Coordinated Entry. Then, explain the project's commitment to ensuring 100% of people are enrolled through the Family and/or the Singles Coordinated Entry System and assessed timely.	
<u>Required Submission:</u> <i>Narrative (300-word limit)</i>	<u>Scoring:</u> + 2 for knowledge, or active involvement, with Coordinated Entry + 1 for describing how 100% of participants are enrolled and assessed timely through the CES 3 Points Total

PART D: INTERVIEW

This section will be conducted with the Rank & Review Committee following the submission of your application. The questions to be asked will be selected by the CoC Board and distributed prior to your interview.

**FY 2026 NEW SSO STANDALONE PROJECT SCORECARD
(EXCEPT CE, STREET OUTREACH AND HMIS)**

PART A: PROJECT DESIGN AND ELIGIBILITY

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
A.1	Project Eligibility	MAG Staff	Narrative	--
A.2	Project Summary	Rank & Review	Narrative	3
A.3	Supportive Services	Rank & Review	Narrative	4
A.4	Client Employment Income at Exit	Rank & Review	Narrative	6
A.5	Returns to Homelessness	Rank & Review	Narrative	6
A.6	Services Participation Requirement	Rank & Review	Narrative	6
A.7	Mainstream Benefits	Rank & Review	Narrative	4
A.8	Reasonable Budget	Rank & Review	File	4
A.9	Service Necessity	Rank & Review	Narrative	5
A.10	Promoting Recovery, Agreements and Commitments	Rank & Review	Narrative	3
A.11	Promoting Recovery (partnerships)	Rank & Review	Narrative	5
				46

PART B: PROJECT/AGENCY EXPERIENCE

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
B.1	Experience with Supportive Services and Connections to Housing or Transitional Housing	Rank & Review	Narrative	4
B.2	Partnerships	Rank & Review	Narrative	3
B.3	Financial Capacity	Rank & Review	Narrative & File	3
				10

PART C: COMMUNITY PRIORITIES

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
C.1	Lived Experience	Rank & Review	Narrative	3
C.2	Data and HMIS	Rank & Review	Narrative	3
C.3	CE Participation	Rank & Review	Narrative	3
				9

PART D: INTERVIEW

<i>Criteria</i>		<i>Scorer</i>	<i>Submission</i>	<i>Points</i>
D	Interview Question(s)	Rank & Review	Interview Response	5

Total Score: 70

Objective Criteria: 65

Objective Rating: 93%

Performance Points: 18

Performance Rating: 26%

FY 2026 NEW SSO STANDALONE PROJECT APPLICATION

PART A: DESIGN AND ELIGIBILITY

A.1 Project Eligibility: Please submit your draft HUD e-snaps application to demonstrate that your project operates under the CoC Project eligible costs under 24 CFR § 578.37. Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your supportive service agreement. Attach your completed Threshold Assessment Checklist.	
<u>Required Submissions:</u> Draft HUD e-snaps Application, Attachments	<u>Scoring:</u> n/a
A.2 Project Summary: Please provide a description that addresses the entire scope of the proposed project, including the type and scale of all assistance to be offered (and the funding source or partnership of each).	
<u>Required Submissions:</u> Narrative (800-word limit)	<u>Scoring:</u> + 1 for comprehensive description of the proposed project + 2 for describing the type and scale of all assistance to be offered 3 Points Total
A.3 Supportive Services: Describe the experience of your agency and your subrecipients (if any) in providing supportive services similar to that proposed in the application. Specifically address your agency and subrecipients strategy for providing supportive services to eligible program participants including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services. If you and your subrecipients (if any) do not have experience providing similar supportive services, explain how you will supplement the lack of experience through partnership with other organizations.	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 2 for describing the strategy for providing services to eligible program participants including those with histories of unsheltered homelessness and those who do not traditionally engage + 2 for demonstration of experience with the type of supportive services proposed to be offered 4 Points Total
A.4 Client Employment Income at Exit: Please describe how your project will help participants secure employment to increase their earned income. This may include the process for developing client service plans for income-related services, or descriptions of services offered.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing plans for developing client service plans for income-related services + 2 for describing the process and experience helping participants secure employment + 2 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.5 Returns to Homelessness: Please describe how your project will help participants not reenter homelessness after their successful exit from the project.	

Approved on 6/29/2026

<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing plans to help participants not reenter homelessness after a successful project exit. + 3 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.6 Services Participation Requirement: Please describe your project's approach requiring project participants participate in services by contract. Attach your supportive service agreement. Participation requirements must be in line with 24 CFR 578.75(h). Examples of services include case management, employment assistance and job training, life skills training, and substance abuse treatment.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the approach to require participants to participate in services described above + 2 for attaching the supportive services agreement + 2 for the quality of the supportive services agreement 6 Points Total
A.7 Mainstream Benefits: Please describe how your project will be supplemented with resources from other public or private sources and participants assisted in obtaining mainstream health, social and employment benefits (SNAP, SSI/SSDI, Medicare, Medicaid, etc.), and how the project will coordinate the provision of mainstream benefits.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing how participants are assisted to obtain mainstream benefits they are eligible for. Detail the partnerships you have established to assist participants with connection to these benefits. + 2 for describing how the project will be supplemented by other public or private sources, which public and private sources and projected amounts 4 Points Total
A.8 Reasonable Budget: Please submit a completed HUD 2026 Project Budget Workbook (located under Documents at maricopacoc.org/fy26-coc-nofo) that matches the summary budget in Question 6J of the draft HUD e-snaps application that demonstrated the average cost per household served for the project is reasonable.	
<u>Required Submission:</u> Budget Chart Form	<u>Scoring:</u> + 2 for completeness and accuracy of the budget + 2 for reasonableness of costs per household served 4 Points Total
A.9 Service Necessity: Please describe how the supportive services project is necessary to assist people in exiting homelessness, addressing barriers to stable housing (e.g., substance use disorder, unemployment, childcare, etc.) and increasing self-sufficiency. Describe how the project will conduct an annual assessment of the service needs of project participants.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the necessity of the supportive services to exit homelessness + 1 for describing how the project will increase self-sufficiency of participants + 2 for describing the annual assessment of service needs of participants

5 Points Total	
A.10 Promoting Recovery, Agreements and Commitments: Please describe your project's approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs. Confirm the project will not operate drug injection sites or "safe consumption sites," knowingly distribute drug paraphernalia, or conduct, permit, encourage or allow any of these activities under the pretext of "harm reduction." This is not a requirement to condition assistance on sobriety or treatment. Acknowledge and certify you will not engage in illegal racial discrimination.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for project's agreement to not distribute or permit the use or distribution of illicit drugs or drug paraphernalia part of the program + 1 for project's commitment to recovery + 1 for your acknowledgement and certification you will not engage in illegal racial discrimination 3 Points Total
A.11 Promoting Recovery: - Identify any partnerships you have with providers and entities 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. - Describe how the project identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as ACT teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment. - Describe any partnerships you have with providers of 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. - Describe how you partner with or provide access to peer recovery specialists or other forms of peer support and recovery navigation. - Identify any partnerships you have with a Certified Community Behavioral Health Clinic (CCBHC) or Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GHBI) provider, or a similar facility;	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 1 for partnerships in connection with Drug Courts, specialty courts, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment. + 1 for describing how you identify individuals experiencing SMI and connect them with the services they need + 1 for describing partnerships with providers of outpatient treatment for mental health and substance use disorders + 1 for describing the partnership with or provide access to peer recovery specialists + 1 for describing the partnership with a CCBHC, CMHC, PATH provider, GHBI provider, or a similar facility 5 Points Total

PART B: EXPERIENCE

B.1 Experience with Supportive Services and Connections to Housing or Transitional Housing: <i>Describe your agency's experience in providing supportive services or a plan for providing services consistent with the activity description at 24 CFR 578.53(e)(13). Describe your effectiveness at helping people successfully exit to treatment projects, transitional housing or permanent housing projects.</i>		
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing the successful work connecting people with next step housing and other resources + 2 for describing the experience or partnerships providing supportive services 4 Points Total	
B.2 Partnerships: <i>Please describe your project's approach integrating healthcare, faith-based and other partnership types into the provision of services and engagement (e.g. partnerships with primary healthcare, off-site substance use disorder treatment, mental health treatment, workforce development, faith-based and other partnership types) and the additional resources (\$s) these partnerships bring to the project (demonstrate the commitment of at least 25% match). Attach MOUs/agreements to demonstrate these partnerships.</i>		
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for describing the agency's approach and experience partnering with the entities described above + 2 for describing the resources (\$s and % of project budget, minimum 25%) these partnerships bring to the project including MOUs /agreements you have to demonstrate these partnerships 3 Points Total	
B.3 Financial Capacity: <i>Please submit your agency's most recent financial audit and management letter or internal audit (if no financial audit is available) OR provide an explanation as to why there has not been an audit. If your audit indicates any findings or concerns, please provide documentation that those findings have been resolved, or the agency has attempted to resolve them. Describe your experience with other federal funding sources. Describe your ability to manage federal compliance requirements, including 2 CFR 200 and 24 CFR 578 (provide examples of good standing on external monitoring).</i>		
<u>Required Submission:</u> Financial audit or internal audit and management letter; documentation of resolution or attempts to resolve Narrative (300-word limit)	<u>Scoring (w/ Findings):</u> + 1 for steps taken to resolve findings from most recent audit or internal audit + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total	<u>Scoring (No Findings):</u> + 1 for audit with no findings + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total

PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: <i>Describe how your agency will take proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.</i>
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<u>Required Submissions:</u> Narrative (300-word limit) Documentation	<u>Scoring:</u> + 2 for lived experience membership on boards or committees + 1 for incorporating lived experience in project design 3 Points Total
C.2 Data and HMIS: Please describe your agency's knowledge of the HMIS. Please explain the project's commitment to collecting accurate data, reviewing it to evaluate participant outcomes and upholding required HMIS data quality standards.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for knowledge, or active involvement, with the Maricopa HMIS + 1 for describing the project's data evaluation and review + 1 for upholding required HMIS data quality standards 3 Points Total
C.3 Coordinated Entry (CE) Participation: Please describe your agency's knowledge of Coordinated Entry. Then, explain the project's commitment to ensuring 100% of people are enrolled through the Family and/or the Singles Coordinated Entry System and assessed timely.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for knowledge, or active involvement, with Coordinated Entry + 1 for describing how 100% of participants are enrolled and assessed timely through the CES 3 Points Total

PART D: INTERVIEW

This section will be conducted with the Rank & Review Committee following the submission of your application. The questions to be asked will be selected by the CoC Board and distributed prior to your interview.

FY 2026 NEW TH PROJECT SCORECARD

PART A: PROJECT DESIGN AND ELIGIBILITY

Criteria		Scorer	Submission	Points
A.1	Project Eligibility	MAG Staff	Narrative	--
A.2	Project Summary	Rank & Review	Narrative	3
A.3	Population Served	Rank & Review	Narrative	3
A.4	Supportive Services	Rank & Review	Narrative	4
A.5	Services Participation Requirement	Rank & Review	Narrative	6
A.6	Client Employment Income at Exit	Rank & Review	Narrative	6
A.7	Returns to Homelessness	Rank & Review	Narrative	6
A.8	Mainstream Benefits	Rank & Review	Narrative	4
A.9	Reasonable Budget	Rank & Review	File	4
A.10	Promoting Recovery, Agreements and Commitments	Rank & Review	Narrative	3
A.11	Promoting Recovery (partnerships)	Rank & Review	Narrative	5
A.12	Promoting Recovery (on-site treatment)	Rank & Review	Narrative	3
				47

PART B: PROJECT/AGENCY EXPERIENCE

Criteria		Scorer	Submission	Points
B.1	Housing Experience	Rank & Review	Narrative	3
B.2	Partnerships	Rank & Review	Narrative	3
B.3	Financial Capacity	Rank & Review	Narrative & File	3
				9

PART C: COMMUNITY PRIORITIES

Criteria		Scorer	Submission	Points
C.1	Lived Experience	Rank & Review	Narrative	3
C.2	Data and HMIS	Rank & Review	Narrative	3
C.3	CE Participation	Rank & Review	Narrative	3
				9

PART D: INTERVIEW

Criteria		Scorer	Submission	Points
D	Interview Question(s)	Rank & Review	Interview Response	5

PART E: BONUS POINTS

Criteria		Scorer	Submission	Points
E	Substance use treatment engagement	Rank & Review	Narrative	3

Total Score: 70

Objective Criteria: 65

Objective Rating: 93%

Performance Points: 18

Performance Rating: 26%

FY 2026 NEW TH PROJECT APPLICATION

PART A: DESIGN AND ELIGIBILITY

A.1. Project Eligibility: Please submit your draft HUD e-snaps application to demonstrate that your project operates under the CoC Project eligible costs under 24 CFR § 578.37. Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your supportive service agreement. Attach your completed Threshold Assessment Checklist.	
<u>Required Submissions:</u> Draft HUD e-snaps Application, Attachments	<u>Scoring:</u> n/a
A.2 Project Summary: Please provide a description that addresses the entire scope of the proposed project, including the type and scale of all assistance to be offered (and the funding source or partnership of each). Include if the proposed project is low barrier and how you define “low barrier”. In case of TH with Rental Assistance subsidy, detail your agreement with a unit of government to administer the Rental Assistance component. Please describe your 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.	
<u>Required Submissions:</u> Narrative (800-word limit)	<u>Scoring:</u> + 1 for comprehensive description of the proposed project + 2 for describing how you will help participants exit homelessness within 24 months 3 Points Total
A.3 Population Served: Please describe your agency’s (or subrecipient’s) experience working with the proposed population. Please describe your experience or plans to have at least 50 percent of participants exit to permanent housing within 24 months and at least 50 percent of participants exit with employment income.	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 1 for comprehensive demonstration of experience with the population + 1 experience or plans to have at least 50 percent of participants exit to permanent housing within 24 months + 1 experience or plans to have at least 50 percent of participants exit with employment income 3 Points Total
A.4 Supportive Services: Please describe your project’s approach 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.) Please describe how the project will assess the service needs of program participants. Describe the service plans for each program participant that should include the services to be provided, when and how often and by whom; program participant goals, strategies for achieving goals, and target dates for achievement to focus on improved health and wellness, housing stability, and increased employment income leading to financial stability and self-sufficiency	
<u>Required Submission:</u> Narrative (500-word limit)	<u>Scoring:</u> + 2 for describing plans to provide services to assist participants to obtain and maintain housing + 2 for describing how the project will assess the service needs of program participants 4 Points Total

Approved on 6/29/2026

A.5 Services Participation Requirement: Please describe your project's approach to require project participants to participate in services by contract, occupancy agreement, or lease. Attach your supportive service agreement. Participation requirements must be in line with 24 CFR 578.75(h). Describe how project participants will be provided with individualized services that will result in at least 20 hours per week of engagement in services, activities or employment for all program participants (e.g. case management, counseling, treatment, volunteering, work therapy, education, job training, community building activities, etc.). Employment may contribute to the 20 hours per week of engagement. Exception for participants over age 62, individuals with handicaps or developmental disability.	
<u>Required Submissions:</u> Narrative (500-word limit)	<u>Scoring:</u> + 2 for describing the approach to require participants to participate in services described above + 2 for describing the customized services that add up to 20h/week with the above exceptions + 2 for the quality of the supportive services agreement 6 Points Total
A.6 Client Employment Income at Exit: Please describe how your project will help participants secure employment to increase their earned income.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing plans that at least 50% of participants exit with employment income + 2 for describing the process and experience helping participants secure employment + 2 for describing plans on how to meet or exceed HUD's performance standard for the metric 6 Points Total
A.7 Returns to Homelessness: Please describe how your project will help participants not reenter homelessness after their successful exit from the project.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for describing plans to help participants not reenter homelessness after a successful project exit + 3 for describing plans on how to meet or exceed current performance standard for the metric 6 Points Total
A.8 Mainstream Benefits: Please describe how your project will be supplemented with resources from other public or private sources and participants assisted in obtaining mainstream health, social and employment benefits (SNAP, SSI/SSDI, Medicare, Medicaid, etc.), and how the project will coordinate the provision of mainstream benefits.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for describing of how participants are assisted to obtain mainstream benefits they are eligible for. Detail the partnerships you have established to assist participants with connection to these benefits. +2 for describing how the project will be supplemented by other public or private sources, which public and private sources and projected amounts 4 Points Total
A.9 Reasonable Budget: Please submit a completed HUD 2026 Project Budget Workbook (located under Documents at maricopacoc.org/fy26-coc-nofo) that matches the summary budget in Question	

6J of the draft HUD e-snaps application that demonstrated the average cost per household served for the project is reasonable.

Required Submission:

Budget Chart Form

Scoring:

+ 2 for completeness and accuracy of the budget
+ 2 for reasonableness of cost per household served

4 Points Total

A.10 Promoting Recovery, Agreements and Commitments: Please describe your project's approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs on the property. Confirm the project will not operate drug injection sites or "safe consumption sites," knowingly distribute drug paraphernalia on or off of property under your control, permit the use or distribution of illicit drugs on property under your control, or conduct, permit, encourage or allow any of these activities under the pretext of "harm reduction." This is not a requirement to condition assistance on sobriety or treatment.

Required Submission:

Narrative (300-word limit)

Scoring:

+ 2 for project's agreement to not operate the above stated sites, and not distribute or permit the use or distribution of illicit drugs on the property under your control
+ 1 for project's commitment to recovery

3 Points Total

A.11 Promoting Recovery:

- Identify any partnerships you have with providers and entities 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.
- Describe how the project identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as ACT teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment.
- Describe any partnerships you have with providers of 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.
- Describe how you partner with or provide access to peer recovery specialists or other forms of peer support and recovery navigation.
- Identify any partnerships you have with a Certified Community Behavioral Health Clinic (CCBHC) or Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GHBI) provider, or a similar facility;

Required Submission:

Narrative (500-word limit)

Scoring:

+ 1 for partnerships in connection with Drug Courts, specialty courts, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment.
+ 1 for describing how you identify individuals experiencing SMI and connect them with the services they need
+ 1 for describing partnerships with providers of outpatient treatment for mental health and substance use disorders
+ 1 for describing the partnership with or provide access to peer recovery specialists
+ 1 for describing the partnership with a CCBHC, CMHC, PATH provider, GHBI provider, or a similar facility

5 Points Total

A.12 Promoting Recovery: Please describe your project's availability of on-site substance use treatment and if so, the partnership you have with a treatment provider.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for project's availability of on-site substance use treatment + 1 for describing the partnership and naming the treatment provider 3 Points Total

PART B: EXPERIENCE

B.1 Housing Experience: Please describe your agency’s (or subrecipient’s) experience in providing housing similar to the intervention proposed in the application. If you do not have experience with the intervention, explain how you will supplement the lack of experience through partnerships.		
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 for comprehensive demonstration of experience 3 Points Total	
B.2 Partnerships: Please describe your project’s approach integrating healthcare, especially behavioral health coordination, law enforcement, faith-based and other partnership types into the provision of services and housing (e.g. partnerships with primary healthcare, on-site and off-site substance use disorder treatment, mental health treatment, workforce development, faith-based and other partnership types) and the additional resources (\$s) these partnerships bring to the project (demonstrate the commitment of at least 25% match). Attach MOUs/agreements to demonstrate these partnerships.		
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for describing the agency’s approach and experience partnering with the entities described above + 2 for describing the resources (\$s and % of project budget, minimum 25%) these partnerships bring to the project including MOUs/ agreements to demonstrate these partnerships 3 Points Total	
B.3 Financial Capacity: Please submit your agency’s most recent financial audit and management letter or internal audit (if no financial audit is available) OR provide an explanation as to why there has not been an audit. If your audit indicates any findings or concerns, please provide documentation that those findings have been resolved, or the agency has attempted to resolve them. Describe your experience with other federal funding sources. Describe your ability to manage federal compliance requirements, including 2 CFR 200 and 24 CFR 578 (provide examples of good standing on external monitoring).		
<u>Required Submission:</u> Financial audit or internal audit and management letter; documentation of resolution or attempts to resolve Narrative (300-word limit)	<u>Scoring (w/ Findings):</u> + 1 steps taken to resolve findings from most recent audit or internal audit + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total	<u>Scoring (No Findings):</u> + 1 for audit with no findings + 1 for experience with other federal funding sources + 1 for ability to manage compliance requirements 3 Points Total

PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: Describe how your agency takes proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.	
<u>Required Submissions:</u> Narrative (300-word limit) Documentation	<u>Scoring:</u> + 2 for lived experience membership on boards or committees + 1 for incorporation of lived experience in project design 3 Points Total
C.2 Data and HMIS: Please describe your agency's knowledge of the HMIS. Please explain the project's commitment to collecting accurate data, reviewing it to evaluate participant outcomes and upholding required HMIS data quality standards.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 1 for knowledge, or active involvement, with the Maricopa HMIS + 1 for describing the project's data evaluation and review approach + 1 for upholding required HMIS data quality standards 3 Points Total
C.3 Coordinated Entry (CE) Participation: Please describe your agency's knowledge of Coordinated Entry. Then, explain the project's commitment to ensuring 100% of people enrolled are referred through the Family and/or the Singles Coordinated Entry System.	
<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for knowledge, or active involvement, with Coordinated Entry + 1 for describing how you will ensure 100% participant enrollment through the CES 3 Points Total

PART D: INTERVIEW

This section will be conducted with the Rank & Review Committee following the submission of your application. The questions to be asked will be selected by the CoC Board and distributed prior to your interview.

PART E: BONUS POINTS

Bonus points may be awarded based on the criteria below. However, bonus points cannot increase an application's final score above the maximum Total Score established for this application.

E.1 Substance use treatment engagement: Bonus points are awarded if CoC-funded units require participant engagement in substance use treatment services as a condition of continued participation. Please state your level of commitment to participants' required engagement in substance use treatment services as a condition of continued program participation.	
<u>Required Submissions:</u> Narrative (300-word limit)	<u>Scoring:</u> + 3 100% of the units require participant engagement + 2 At least 50% of the units require participant engagement 3 Points Max

FY 2026 RENEWAL PSH/RRH PROJECT SCORECARD

PART A: PROJECT DESIGN AND ELIGIBILITY- THRESHOLD

Criteria		Applies to	Scorer	Submission
A.1	Project Eligibility	PSH/RRH	MAG Staff	File
A.2	Project Summary	PSH/RRH	MAG Staff	Narrative

PART B: PROJECT PERFORMANCE

Criteria		Applies to	Scorer	Submission	Total Points
B.1	Positive Exit Destinations	PSH/RRH	Auto	APR Data	5
B.2	Returns to Homelessness (Exits to Homeless Destinations)	PSH/RRH	Auto	APR Data	6
B.3	Client Employment Income (Earned Income)	PSH/RRH	Auto	APR Data	6
B.4	Non-employment Cash Income	PSH/RRH	Auto	APR Data	4
B.5	Mainstream Benefits	PSH/RRH	Rank & Review	Narrative	4
B.6	Service Participation Requirement	PSH/RRH	Rank & Review	Narrative	6
B.7	High Need Population	PSH/RRH	Auto	APR Data	6
B.8	Utilization Rate	PSH/RRH	Auto	APR & CoC App	5
B.9	Monitoring	PSH/RRH	MAG Staff	Narrative & MAG Staff	4
B.10	Grant Spenddown	PSH/RRH	Auto	APR Data	5
B.11	Promoting Recovery, Agreements and Commitments	Rank & Review	Rank & Review	Narrative	3
B.12	Promoting Recovery (on-site treatment)	Rank & Review	Rank & Review	Narrative	3
B.13	Performance Discretionary	PSH/RRH	Rank & Review	Narrative	4
Sub-Total					61

PART C: COMMUNITY PRIORITIES

Criteria		Applies to	Scorer	Submission	Total Points
C.1	Lived Experience	PSH/RRH	Rank & Review	Narrative	3
C.2	Data and HMIS	PSH/RRH	Auto	APR Data	3
C.3	CE Acceptance	PSH/RRH	Auto	HMIS Data	3
Sub-Total					9

PART D: BONUS POINTS

Criteria		Applies to	Scorer	Submission	Points
D	Substance use treatment engagement	PSH/RRH	Rank & Review	Narrative	3

Total Score: 70

Objective Criteria: 66

Objective Rating: 94%

Performance Points: 18

Performance Rating: 26%

FY 2026 RENEWAL PSH/RRH PROJECT APPLICATION

PART A: PROJECT DESIGN AND ELIGIBILITY- THRESHOLD

A.1 Project Eligibility: Please verify your project's eligibility as a recipient of the CoC grant. Submit the project's draft HUD e-snaps application. Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your supportive service agreement. Attach your completed Threshold Assessment Checklist.	
Required Submissions: Draft HUD e-snaps Application; HUD Grant Agreement, Attachments.	Scoring: n/a
A.2 Project Summary: Please summarize the day-to-day operation of your project with details on the type and scale of assistance to be offered (including the funding source or partnership of each). [For PSH:] Include the number and configuration of units and describe how they fit the needs of the program participants. [For RRH:] Describe how the provision of tenant-based rental assistance will help individuals and families achieve self-sufficiency within 24 months.	
Required Submission: Narrative (800-word limit)	Scoring: n/a

PART B: PROJECT PERFORMANCE

System performance benchmarks were obtained by averaging CY2023, federal fiscal year 2024 and CY2024 System Annual Performance Report key performance indicators (KPI¹), calculated using the definitions below. The benchmarks are included in the middle of the bolded scoring ranges for each of the KPIs below. As the system performs at the respective average, it is expected that individual projects perform in that range as well. Projects that performed above the average are awarded the top score for the respective KPI. Project performance is assessed for the most recently closed federal fiscal year, 10/1/2024 – 09/30/2025, using APR and HMIS custom reports information for this timeframe, and the most recently submitted APR in Sage for the financial information.

Permanent Supportive Housing (PSH) scoring ranges are marked in black and Rapid Rehousing (RRH) in blue.

B.1 Positive Exit Destinations: As reported in the APR, the percentage of people who exited the project during the year to a permanent destination (PSH/RRH) or continued to be stably housed (PSH).		
Data Autoscored: APR Qs 23c, 5a PSH: (5a8 Number of Stayers + Q23c Total persons exiting to Permanent Situations) / (5a1 Total number of persons served – Q23c Total persons whose destination excluded) RRH: Q23c Total persons exiting to Permanent Situations / (Q23c Total –	Scoring (PSH): 5 = 95% or more 4 = 93 – 94.9% 3 = 90 – 92.9% 2 = 87 – 89.9% 1 = 84 – 86.9% 0 = less than 84% 5 Points Total	Scoring (RRH): 5 = 82% or more; 4 = 79 – 81.9%; 3 = 76 – 78.9%; 2 = 72 – 75.9%; 1 = 68 – 71.9%; 0 = less than 68%; 5 Points Total

¹ A key performance indicator (KPI) is a quantifiable metric that tracks progress toward a specific goal and serves as a performance benchmark that helps assess success over time.

Q23c Total persons whose destination excluded)		
B.2 Returns to Homelessness (Exits to Homeless Destinations): <i>As reported in the APR, the percentage of people in the project who exited the project during the year to a homeless situation (place not meant for habitation, emergency shelter, including hotel or motel, host homes and safe haven) (measure closest to recidivism).</i>		
<u>Data Autoscored:</u> APR Q 23 Q23c Subtotal - Homeless Situations / (Q23c Total – Q23c Total persons whose destination excluded)	<u>Scoring (PSH):</u> 6 = 15.9% or less 4 = 16 - 20.9% 2 = 21 - 25.9% 0 = more than 26% 6 Points Total	<u>Scoring (RRH):</u> 6 = 8.9% or less 4 = 9 - 11.9% 2 = 12 - 14.9% 0 = more than 15% 6 Points Total
B.3 Client Employment Income (Earned Income): <i>As reported in the APR, the percentage of people aged 18 and older who maintained or increased their earned income at the end of the operating year or project exit, either by maintaining or gaining employment or by increasing the amount of their earned income.</i>		
<u>Data Autoscored:</u> APR Qs 19a1, 19a2, 18 (Q19a1 Number of Adults with Earned Income Retained and Same + Retained and Increased + Gained + Q19a2 Number of Adults with Earned Income Retained and Same + Retained and Increased + Gained) / (Q18 Total Adults – Q18 Number of Adult Stayers Not Yet Required to Have an Annual Assessment Number of Adults at Annual Assessment)	<u>Scoring (PSH):</u> 6 = 11% or more 5 = 8 – 10.9% 4 = 5 – 7.9% 2 = 3 – 4.9% 0 = less than 3% 6 Points Total	<u>Scoring (RRH):</u> 6 = 32% or more; 5 = 27 – 31.9%; 4 = 22 – 26.9%; 2 = 17 – 21.9%; 0 = less than 17%; 6 Points Total
B.4 Non-employment cash Income: <i>As reported in the APR, the percentage of people aged 18 and older who maintained or increased their non-employment cash income at the end of the operating year or program exit.</i>		
<u>Data Autoscored:</u> APR Qs 19a1, 19a2, 18 (Q19a1 Number of Adults with Only Other Income Retained and Same + Retained and Increased + Gained + Q19a2 Number of Adults with Only Other Income Retained and Same + Retained and Increased + Gained) / (Q18 Total Adults – Q18 Number of Adult Stayers Not Yet Required to Have an Annual Assessment Number of Adults at Annual Assessment)	<u>Scoring (PSH):</u> 4 = 54% or more 3 = 49 – 53.9% 1 = 44 – 48.9% 0 = less than 44% 4 Points Total	<u>Scoring (RRH):</u> 4 = 36% or more 3 = 30 – 35.9% 1 = 25 – 29.9% 0 = less than 25% 4 Points Total
B.5 Mainstream Benefits: <i>Please describe how your project will be supplemented with resources from other public or private sources and participants will be assisted in obtaining mainstream health, social and employment benefits (SNAP, SSI/SSDI, Medicare, Medicaid, etc.), and how the project will coordinate the provision of mainstream benefits.</i>		
<u>Required Submission:</u>	<u>Scoring:</u>	

Narrative (300-word limit)		+ 2 for describing how participants are assisted to obtain mainstream benefits they are eligible for. Detail the partnerships you have established to assist participants with connection to these benefits. + 2 for describing how the project will be supplemented by other public or private sources, which public and private sources and projected amounts	
		4 Points Total	
B.6 Service Participation Requirement: Please describe your project's approach to require project participants to participate in services by contract, occupancy agreement, or lease. Attach your supportive service agreement. Participation requirements must be in line with 24 CFR 578.75(h). Examples of services include case management, employment assistance and job training, life skills training, and substance use disorder treatment.			
Required Submission: Narrative (300-word limit)		Scoring: + 2 for describing the approach to require participants to participate in services described above + 2 for describing partnerships with public or private sources and the resources (\$s and % of project budget) these partnerships will bring + 2 for attaching a compliant supportive services agreement	
		6 Points Total	
B.7 High Need Population: As reported in the APR, the percentage of people served by the project who are high need at entry, including: Disabled Households, Unsheltered Adults, Older Adults (age 65 and over), Adult Victims of Domestic Violence or Sexual Assault.			
Data Autoscored:		6 points Maximum	6 points Maximum
a. Disabled Households with 2 and 3 conditions at entry APR Qs 13a2, 8a PSH: (Q13a2 2 Conditions+ Q13a2 3+ Conditions) / Q8a Total Households Served who Moved into Housing RRH: (Q13a2 2 Conditions+ Q13a2 3+ Conditions) / Q8a Total Households		Scoring Disabled (PSH): 3 = 81% or more 2 = 76 – 80.9% 1 = 71 – 75.9% 0 = less than 71%	Scoring Disabled (RRH): 3 = 49% or more; 2 = 44 – 48.9%; 1 = 39 – 43.9%; 0 = less than 39%;
		3 Points Total	3 Points Total
b. Unsheltered Adults: APR Q 15 Q15 "Place not meant for habitation" / Q5a2 Number of Adults		Unsheltered (PSH): 3 = 40% or more 2 = 35 – 39.9% 1 = 29 – 34.9% 0 = less than 29%	Unsheltered (RRH): 3 = 38% or more; 2 = 33 – 37.9%; 1 = 28 – 32.9%; 0 = less than 28%;
		3 Points Total	3 Points Total
c. Older Adults (age 65 and over) APR Q 11 Q11 65+ / Q5a2 Number of Adults		Older Adults (age 65 and over) (PSH): 3 = 13% or more 2 = 10% – 12.9% 1 = 7% – 9.9% 0 = less than 7%	Older Adults (age 65 and over)(RRH): 3 = 13% or more 2 = 10 – 12.9% 1 = 7 – 9.9% 0 = less than 7%
		3 Points Total	3 Points Total
d. Adult Victims of Domestic Violence or Sexual Assault APR Qs 14a, Q5a Q14a Yes / Q5a2 Number of Adults		Adult Victims of Domestic Violence or Sexual Assault (PSH): 3 = 32% or more 2 = 27 – 31.9%	Adult Victims of Domestic Violence or Sexual Assault (RRH): 3 = 30% or more; 2 = 25 – 29.9%;

	1 = 22 – 26.9% 0 = less than 22% 3 Points Total	1 = 20 – 24.9%; 0 = less than 20%; 3 Points Total
B.8 Utilization Rate: As reported in the APR, the average utilization rate during the operating year.		
Data Autoscored: APR Q 08b, CoC e-snaps App PSH: (Q08b January + April + July + October)/4 / Project UNIT Capacity RRH: (Q08b January + April + July + October)/4 / (Project Full Capacity for One Night as Committed in the CoC Application, Screen 5A, Total Number of Households)	Scoring (PSH): 5 = 96% or more 4 = 93 – 95.9% 3 = 90 – 92.9% 2 = 87 – 89.9% 1 = 84 – 86.9% 0 = less than 84% 5 Points Total	Scoring (RRH): 5 = 84% or more 4 = 80 – 83.9% 3 = 76 – 79.9% 2 = 72 – 75.9% 1 = 68 – 71.9% 0 = less than 68% 5 Points Total
B.9 Monitoring: Please provide an explanation for any HUD or MAG monitoring letters related to projects open January 1, 2024 to present. These include notices provided by MAG for Sage reporting, quarterly grant spenddown, or data quality, and open monitoring findings from either MAG or HUD.		
Required Submission: Narrative and MAG Staff Narrative (300-word limit)	Scoring (w/ Findings): + 2 for identified steps to remediate open findings or issues + 2 for no past due reporting or untimely monitoring activities 4 Points Total	Scoring (No Findings): + 4 for a project having no open monitoring findings, notices, or delayed submission of required reports 4 Points Total
B.10 Grant Spenddown: Percentage of disbursed HUD funding used for the most recent closed operating year, as reported in SAGE.		
Data Autoscored: Sage	Scoring: 5 = 98% – 100% 4 = 95% – 97.9% 2 = 90% – 94.9% 1 = Less than 90% 5 Points Total	
B.11 Promoting Recovery, Agreements and Commitments: Please describe your project’s approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs on the property. Confirm the project will not operate drug injection sites or “safe consumption sites,” knowingly distribute drug paraphernalia on or off of property under your control, permit the use or distribution of illicit drugs on property under your control, or conduct, permit, encourage or allow any of these activities under the pretext of “harm reduction.” This is not a requirement to condition assistance on sobriety or treatment. Acknowledge and certify you will not engage in illegal racial discrimination.		
Required Submission: Narrative (300-word limit)	Scoring: + 1 for your agreement to not operate the above stated sites, and not distribute or permit the use or distribution of illicit drugs on the property under your control + 1 for project’s commitment to recovery + 1 for your acknowledgement and certification you will not engage in illegal racial discrimination 3 Points Total	
B.12 Promoting Recovery: Please describe your project’s availability of on-site substance use treatment and if so, the partnership you have with a treatment provider.		

<u>Required Submission:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for project's availability of on-site substance use treatment + 1 for describing the partnership and naming the treatment provider 3 Points Total
B.13 Performance Discretionary: Agencies may submit a narrative to supplement the performance data above. The narrative should explain why full points were not received and what will be done moving forward to improve upon current project performance.	
<u>Required Submissions:</u> Narrative (300-word limit)	<u>Scoring:</u> 2 = why were full points not received 2 = what will be done to improve current performance 4 Points Total

PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: Describe how your project takes proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.		
<u>Required Submissions:</u> Narrative (300-word limit)	<u>Scoring:</u> + 2 for lived experience membership on boards or committees + 1 for incorporation of lived experience in project design 3 Points Total	
C.2 Data and HMIS: As reported in the APR, the percentage of total HMIS fields across all persons served that are missing or in error.		
<u>Data Autoscored:</u> APR Qs: 5a, 6a, 6b, 6c, 6d (Q6a Total errors for Name, Date of Birth, Race/Ethnicity + Q6b Total errors for Project Start Date, Relationship to HoH, Disabling Condition + Q6c Destination, Income and Sources at Start, Annual Assessment, and Exit + 6d Total errors)/ Q5a1 Total Number of Persons Served	<u>Scoring (PSH):</u> 3 = less than 19% 2 = 19 – 21.9% 1 = 22 – 23.9% 0 = more than 24% 3 Points Total	<u>Scoring (RRH):</u> 3 = less than 22%; 2 = 22 – 24.9%; 1 = 25 – 26.9%; 0 = more than 27%; 3 Points Total
C.3 Coordinated Entry (CE) Acceptance: As reported in HMIS, the percentage of eligible referrals accepted by the project from the Family and/or the Singles Coordinated Entry System.		
<u>Data Autoscored:</u> HMIS Report	<u>Scoring:</u> 3 = 95% or more 2 = 90% – 94.9% 1 = 80% – 89.9% 0 = Less than 80% 3 Points Total	

PART D: BONUS POINTS

Bonus points may be awarded based on the criteria below. However, bonus points cannot increase an application's final score above the maximum Total Score established for this application.

Approved on 6/29/2026

D.1 Substance use treatment engagement: Bonus points are awarded if CoC-funded units require participant engagement in substance use treatment services as a condition of continued participation. Please state your level of commitment to participants' required engagement in substance use treatment services as a condition of continued program participation.

Required Submissions:

Narrative (300-word limit)

Scoring:

+ **3** 100% of the units require participant engagement

+ **2** At least 50% of the units require participant engagement

3 Points Max

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

1D-2c. Local Competition Selection Results

LOCAL COMPETITION SELECTION RESULTS

	Field Office:	San Francisco									
	CoC Number:	AZ-502									
	CoC Name:	Phoenix, Mesa/Maricopa County CoC									
	CA Name:	Maricopa Association of Governments									
	DV ARD (Estimated):	\$900,578									
	YHDP ARD (Estimated):	\$0									
	CoC's ARD (Estimated):	\$48,607,126									
Applicant and Project Information											
#	Applicant Name	Project Name	Score	Status	Rank	Requested Funding Amount	Reallocated Funds	FY26 Priority	Tier	Fund Source	Project Component
1	Maricopa Association of Governments	CoC Planning	Not Scored	Accepted	Not Ranked	\$ 1,500,000.00	\$ -				
2	*ABC	Casa De Salud	Held Harmeless	Accepted	1	\$ 1,497,315.00	\$ -	1 Held harmless	Tier 1	ARD	PSH
3	*UMOM	Regional Coordinated Entry MC	Held Harmeless	Accepted	2	\$ 634,942.00	\$ -	1 Held harmless	Tier 1	ARD	SSO-CE
4	Keys to Change	Regional Coordinated Entry MC FY2024	Held Harmeless	Accepted	3	\$ 1,028,801.00	\$ -	1 Held harmless	Tier 1	ARD	SSO-CE
5	Solari	Solari - HMIS Renewal Project Application FY 2024	Held Harmeless	Accepted	4	\$ 951,694.00	\$ -	1 Held harmless	Tier 1	ARD	HMIS
6	*NAC	Stepping Stones III	63	Accepted	5	\$ 584,437.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
7	*NAC	Stepping Stones II	62	Accepted	6	\$ 1,033,728.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
8	*ABC	SPC 189	58	Accepted	7	\$ 4,000,988.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
9	*ABC	Casa Mia de Paz	58	Accepted	8	\$ 3,706,663.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
10	*ABC	Another Chance	55	Accepted	9	\$ 2,456,479.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
11	*NAC	Camelback Pointe	55	Accepted	10	\$ 1,549,869.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
12	*ABC	HUD 6108	54	Accepted	11	\$ 3,049,116.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
13	*ABC	SPC 293	52	Accepted	12	\$ 6,175,870.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
14	*ABC	Casa de Luz	49	Accepted	13	\$ 1,112,575.00	\$ -	2 PSH to Preserve	Tier 1	ARD	PSH
53	*UMOM	Next Step Housing 3 Consolidated	47	Accepted	14	\$ 1,381,798.60	\$ -	3 Family RRH	Tier 1	ARD	RRH
15	*LEAF	A New Leaf Domestic Violence Rapid Re- Housing Application	53	Accepted	15	\$ 900,578.00	\$ -	3 Family RRH	Tier 2	ARD	RRH
16	*SC Sojourner Center	Transitional Housing DV Bonus Project at Sojourner Center	57	Accepted	16	\$ 531,055.00	\$ -	4 DV Bonus: TH	Tier 2	DV Bonus	DV-TH
17	Rooted in Grace Foundation	Health + Housing	59	Accepted	17	\$ 280,000.00	\$ -	4 DV Bonus: TH	Tier 2	DV Bonus	DV-TH
18	*STF Save the Family	STF - Rapid Rehousing	68	Accepted	18	\$ 550,293.00	\$ -	5 DV Bonus: RRH	Tier 2	DV Bonus	DV-RRH
19	*ABC	Transitional - PSH 2009	64	Accepted	19	\$ 924,899.00	\$ 924,899.00	6 Transition Grants	Tier 2	ARD	TH
20	*ABC	Transitional - PSH 2016	64	Accepted	20	\$ 2,011,202.00	\$ 2,011,202.00	6 Transition Grants	Tier 2	ARD	TH
21	*ABC	Transitional - SPC 151	64	Accepted	21	\$ 3,174,194.00	\$ 3,174,194.00	6 Transition Grants	Tier 2	ARD	TH
22	*ABC	Transitional - Village	64	Accepted	22	\$ 3,727,872.00	\$ 3,727,872.00	6 Transition Grants	Tier 2	ARD	TH
23	*ABC	Transitional PSH 3109	64	Accepted	23	\$ 1,460,303.00	\$ 1,460,303.00	6 Transition Grants	Tier 2	ARD	TH
24	*CBI	CBI Transitional Housing Scattered Site	64	Accepted	24	\$ 1,386,627.00	\$ 1,386,627.00	6 Transition Grants	Tier 2	ARD	TH
25	*CBI	Rio Transitional Housing	64	Accepted	25	\$ 1,894,546.00	\$ 1,894,546.00	6 Transition Grants	Tier 2	ARD	TH
27	*UMOM	Next Step Housing TH	53	Accepted	26	\$ 1,257,017.00	\$ 1,257,017.00	6 Transition Grants	Tier 2	ARD	TH
28	*STF Save the Family	STF Step Up Housing - Transitional Housing	69	Accepted	27	\$ 232,797.00	\$ 232,797.00	7 New Projects	Tier 2	ARD	TH
29	AZCEND	AZCEND Housing Stability and Supportive Service Project	68	Accepted	28	\$ 248,700.00	\$ 248,700.00	7 New Projects	Tier 2	ARD	SSO-SA
30	Copa Health	Pathways of Hope	67	Accepted	29	\$ 1,674,717.00	\$ 1,674,717.00	7 New Projects	Tier 2	ARD	TH
31	*LEAF	East Valley Men's Center- Supportive Services Only	66	Accepted	30	\$ 253,330.00	\$ 253,330.00	7 New Projects	Tier 2	ARD	SSO-SA
32	*TCAA	TCAA Supportive Services for Individuals Experiencing Homelessness	66	Accepted	31	\$ 760,528.00	\$ 296,068.40	7 New Projects	Tier 2	ARD/CoC Bonus	SSO-SA
33	Axiom Community of Recovery	ACR Housing Stabilization Initiative	66	Accepted	32	\$ 950,747.00	\$ -	7 New Projects	Tier 2	CoC Bonus	SSO-SA
34	Maggie's Place	Recovery for Pregnant Moms Experiencing Homelessness - Passion, Power, Purpose	63	Accepted	33	\$ 418,325.00	\$ -	7 New Projects	Tier 2	CoC Bonus	SSO-SA
35	*CASS	Emergency Shelter and Supportive Services for Seniors Experiencing Homelessness	61	Accepted	34	\$ 759,358.00	\$ -	7 New Projects	Tier 2	CoC Bonus	SSO-SA
36	City Help	Transitional Pathways of Success	61	Accepted	35	\$ 300,000.00	\$ -	7 New Projects	Tier 2	CoC Bonus	TH
37	*LEAF	East Valley Men's Center - Transitional Housing	59	Accepted	36	\$ 816,774.00	\$ -	7 New Projects	Tier 2	CoC Bonus	TH
38	*JC Justa Center	Senior Only Shelter: A Justa Center Collaborative	55	Accepted	37	\$ 427,522.00	\$ -	7 New Projects	Tier 2	CoC Bonus	SSO-SA
41	Mercy House Living Centers	Mercy House Transitional Housing Project	58	Accepted	38	\$ 862,814.40	\$ -	7 New Projects	Tier 2	CoC Bonus	TH
39	*CBI	CFH Transitional Housing	64	Rejected		\$ 1,967,047.00	\$ -	6 Transition Grants	Rejected		TH
40	*TCAA	TCAA Transitional Housing 2026	65	Rejected		\$ 614,785.00	\$ -	7 New Projects	Rejected		TH
42	*UMOM	UMOM - Transitional Housing for Single Women	53	Rejected		\$ 1,613,603.00	\$ -	7 New Projects	Rejected		TH
43	*ABC	PSH 2009		Fully Reallocated		\$ -	\$ (924,899.00)	8 Unranked	Reallocation		PSH
44	*ABC	PSH 2016		Fully Reallocated		\$ -	\$ (2,011,202.00)	8 Unranked	Reallocation		PSH
45	*ABC	PSH 3109		Fully Reallocated		\$ -	\$ (1,460,303.00)	8 Unranked	Reallocation		PSH
46	*ABC	SPC 151		Fully Reallocated		\$ -	\$ (3,174,194.00)	8 Unranked	Reallocation		PSH
47	*ABC	Village		Fully Reallocated		\$ -	\$ (3,727,872.00)	8 Unranked	Reallocation		PSH
48	*CASS	CASS Rapid Rehousing		Fully Reallocated		\$ -	\$ (402,714.00)	8 Unranked	Reallocation		RRH
49	*CBI	CBI PSH 54		Fully Reallocated		\$ -	\$ (1,386,627.00)	8 Unranked	Reallocation		PSH
50	*CBI	CBI PSH 74		Fully Reallocated		\$ -	\$ (1,967,047.00)	8 Unranked	Reallocation		PSH
51	*CBI	CBI PSH 75		Fully Reallocated		\$ -	\$ (1,894,546.00)	8 Unranked	Reallocation		PSH
52	*NAC	Stepping Stones		Fully Reallocated		\$ -	\$ (104,047.00)	8 Unranked	Reallocation		PSH
53	*UMOM	Next Step Housing 3 Consolidated		Reduced Reallocated		\$ -	\$ (231,804.40)	3 Family RRH	Reallocation		RRH
54	*UMOM	Next Step Housing		Fully Reallocated		\$ -	\$ (1,257,017.00)	8 Unranked	Reallocation		RRH
Total Prioritized and Ranked						\$56,468,474	\$0.00				

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

2A-8b. FY 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

AZ-502 - Phoenix, Mesa/Maricopa County 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

AZ-502 - Phoenix, Mesa/Maricopa County 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

AZ-502 - Phoenix, Mesa/Maricopa County 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	14,414	113.8	71.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	16,377	131.4	83.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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”)	15,951	763.9	316.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	17,754	736.0	308.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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	808	142	17.6%	49	6.1%	57	7.1%	248	30.7%
Exit was from ES	4,371	514	11.8%	268	6.1%	391	9.0%	1,173	26.8%
Exit was from TH	728	48	6.6%	39	5.4%	36	5.0%	123	16.9%
Exit was from SH	94	9	9.6%	8	8.5%	12	12.8%	29	30.9%
Exit was from PH	2,582	193	7.5%	162	6.3%	204	7.9%	559	21.7%
TOTAL Returns to Homelessness	8,583	906	10.6%	526	6.1%	700	8.2%	2,132	24.8%

2025 HDX Competition Report

2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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	16,556
Emergency Shelter Total	14,456
Safe Haven Total	128
Transitional Housing Total	2,619

2025 HDX Competition Report

2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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)	1,815
Number of adults with increased earned income	128
Percentage of adults who increased earned income	7.1%

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2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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)	1,815
Number of adults with increased non-employment cash income	827
Percentage of adults who increased non-employment cash income	45.6%

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

Metric	Value
Universe: Number of adults (system stayers)	1,815
Number of adults with increased total income	923
Percentage of adults who increased total income	50.9%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	714
Number of adults who exited with increased earned income	125
Percentage of adults who increased earned income	17.5%

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2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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)	714
Number of adults who exited with increased non-employment cash income	145
Percentage of adults who increased non-employment cash income	20.3%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	714
Number of adults who exited with increased total income	257
Percentage of adults who increased total income	36.0%

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2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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.	13,964
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.	4,682
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)	9,282

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AZ-502 - Phoenix, Mesa/Maricopa County 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.	15,933
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.	5,637
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.)	10,296

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AZ-502 - Phoenix, Mesa/Maricopa County 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	14,656
Of persons above, those who exited to temporary & some institutional destinations	3,884
Of the persons above, those who exited to permanent housing destinations	1,502
% Successful exits	36.8%

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2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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	12,938
Of the persons above, those who exited to permanent housing destinations	5,783
% Successful exits	44.7%

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	5,288
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	5,075
% Successful exits/retention	96.0%

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2026 Competition Report - SPM Data

AZ-502 - Phoenix, Mesa/Maricopa County 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)	14,654	2,621	5,985	4,936	11,618
Total Leavers (HMIS)	11,651	1,817	852	2,870	8,229
Destination of Don't Know, Refused, or Missing (HMIS)	3,400	327	84	55	2,314
Destination Error Rate (Calculated)	29.2%	18.0%	9.9%	1.9%	28.1%

2025 HDX Competition Report

2026 Competition Report - SPM Notes

AZ-502 - Phoenix, Mesa/Maricopa County 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

AZ-502 - Phoenix, Mesa/Maricopa County 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	4,126	3,726	3,933	0	3,933	94.7%
SH	45	45	45	0	45	100.0%
TH	1,968	1,101	1,891	0	1,891	58.2%
RRH	1,683	1,683	1,683	0	1,683	100.0%
PSH	6,283	4,949	6,283	0	6,283	78.8%
OPH	697	189	697	336	361	52.4%
Total	14,802	11,693	14,532	336	14,196	82.4%

2025 HDX Competition Report

2026 Competition Report

AZ-502 - Phoenix, Mesa/Maricopa

For HIC conducted in January/February

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	4,126	193	193	0	193	100.00%
SH	45	0	0	0	0	NA
TH	1,968	77	77	0	77	100.00%
RRH	1,683	0	0	0	0	NA
PSH	6,283	0	0	0	0	NA
OPH	697	0	0	0	0	NA
Total	14,802	270	270	0	270	100.00%

2025 HDX Competition Report

2026 Competition Report

AZ-502 - Phoenix, Mesa/Maricopa

For HIC conducted in January/February

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	4,126	3,919	4,126	94.98%
SH	45	45	45	100.00%
TH	1,968	1,178	1,968	59.86%
RRH	1,683	1,683	1,683	100.00%
PSH	6,283	4,949	6,283	78.77%
OPH	697	189	361	52.35%
Total	14,802	11,963	14,466	82.70%

2025 HDX Competition Report

2026 Competition Report - HIC Summary

AZ-502 - Phoenix, Mesa/Maricopa County 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

AZ-502 - Phoenix, Mesa/Maricopa County CoC

For PIT conducted in January/February of 2026

Submission Information

Date of PIT Count	Received HUD Waiver
1/26/2026	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	4,174	3,327	3,681
Safe Haven Total	34	35	38
Transitional Housing Total	1,151	1,165	1,440
Total Sheltered Count	5,359	4,527	5,159
Total Unsheltered Count	4,076	5,207	4,567
Total Sheltered and Unsheltered Count*	9,435	9,734	9,726

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	1,478	1,006	996
Total Unsheltered Count	657	924	985
Total	2,135	1,930	1,981

AZ-502 Phoenix/Mesa/Maricopa County Regional CoC

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

MARICOPA REGIONAL CONTINUUM OF CARE (COC) ADVANCING RECOVERY AND PROHIBITIONS AGAINST ILLICIT DRUG ENABLEMENT POLICY

POLICY

The Maricopa Regional Continuum of Care (CoC) strictly prohibits all CoC-funded housing projects from operating drug injection sites, otherwise known as "safe consumption sites", from knowingly distributing drug paraphernalia on or off property under their control, knowingly permitting the use or distribution of illicit drugs on property under their control, or conducting, permitting or encouraging any of the aforementioned activities under the pretext of "harm reduction".

CoC funding recipients must certify that they will comply with this policy as part of the annual CoC Notice of Funding Opportunity (NOFO) application process. This certification does not require program participants to maintain sobriety as a condition of assistance, participate in treatment as a condition of assistance, or be evicted from housing or exited from assistance for a first-time violation of a drug-related program policy or lease requirement.

Should a CoC-funded housing project be determined to be in violation of this policy, the CoC will request the project to come into compliance with the policy. If the recipient fails to implement required corrective actions and achieve compliance, the recipient will be ineligible to apply under future CoC NOFOs until the project comes into compliance with the policy.

The CoC encourages the provision of substance use disorder treatment and recovery housing within or outside of the CoC-funded projects.

The CoC will not restrict or prohibit CoC-funded recipients to operate 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.

ATTACHMENT A. DOCUMENT VERSION HISTORY & RATIONALE

This log provides a concise record of changes to the Policy, including when updates were made, what was changed, and the rationale behind the revisions. This supports transparency, continuity, and onboarding of new leaders/staff.

VERSION HISTORY TABLE

Version	Date Approved	Section(s) Updated	Summary of Changes	Rationale / Reason for Update	Approved By
1.0	July 13, 2026	All	Adopted policy	Adopted policy	CoC Board



Substance Abuse and Mental Health
Services Administration

5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)



July 29, 2025

Dear Colleague:

The U.S. remains in the midst of an evolving and dynamic overdose crisis, driven by exposure to highly potent synthetic opioids like illicitly made fentanyl and adulterants like xylazine and medetomidine in the illicit drug supply. In the past decade, over a million people have died from a drug overdose, and no segment of society has been untouched by this crisis. [CDC's latest provisional data](#) show that overdose deaths have declined 26% in the 12-months ending February 2025 compared to the prior year. Although this is a very welcome trend, this still translates to nearly 80,000 deaths a year – more than 200 Americans dying every day.

In recent years, the life-saving opioid overdose reversal medications (OORMs), naloxone and nalmefene, have been lumped into an ideological concept of harm reduction which has been used to advocate for policies that are incompatible with Federal laws and inconsistent with this Administration's priorities.

This conflation of harm reduction with OORMs has caused an unnecessary distraction from the ultimate goal of saving lives and has served as a barrier to getting lifesaving OORMs into some communities in our Nation. Yet, we know these medications are one of the most effective life-saving tools in our fight against overdose. Naloxone and nalmefene work by reversing or blocking the effects of opioids and restoring breathing. These medications are available by prescription, and naloxone is also available under standing orders, from community-based organizations, and nasal spray formulations are available over-the-counter (OTC).

Given the urgency of the overdose crisis, together, we must continue to focus our efforts on saving lives. To advance these efforts and to provide clarity on the Administration's position on harm reduction, on July 24, 2025, President Trump issued an [Executive Order \(EO\) on Ending Crime and Disorder on America's Streets](#). In the EO, the President directed the Secretary of Health and Human Services to take appropriation action to "ensure that discretionary grants issued by the Substance Abuse and Mental Health Services Administration for substance use disorder prevention, treatment, and recovery fund evidence-based programs and do not fund programs that fail to achieve adequate outcomes, including so-called "harm reduction" or "safe consumption" efforts that only facilitate illegal drug use and its attendant harm.

Moving forward, SAMHSA funds will no longer be used to support poorly defined so-called "harm reduction" activities; rather, SAMHSA is providing guidance to state agency leadership and to grantees through new award terms and conditions that provide clarity on what supplies and services previously defined under the umbrella of harm reduction can be supported with SAMHSA funding. We also are including information on services and supplies that cannot be supported with SAMHSA funds. This information will be updated on SAMHSA's website.

The following are supplies and services that **CAN be supported with SAMHSA funding**:

Life-Saving Overdose Prevention and Response Services

- Opioid overdose reversal supplies, including the purchase of naloxone and nalmefene (OORMs)
- Substance test kits, including fentanyl test strips and xylazine test strips
- Medication lock boxes and medication disposal kits
- Overdose reversal education and training services
- Distribution mechanisms (e.g., bags or metal boxes/containers) for OORMs

Infectious Disease Prevention Services

- Wound care supplies
- FDA-approved home testing kits for viral hepatitis (i.e., HBV and HCV) and HIV
- Sharps disposal kits
- Educational materials on HIV and viral hepatitis and prevention, testing, treatment, and care services
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, testing, treatment, and care services — including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother to child transmission, and partner services
- Referral to hepatitis A and hepatitis B vaccinations (to reduce risk of viral hepatitis infection)
- Provision of education on HIV and viral hepatitis prevention, testing, and referral to treatment services
- Education and activities to reduce risk of STIs, including distributing condoms
- Provision of information on local resources and/or referrals for PrEP

Other Supplies and Services

- Nicotine cessation therapies
- Food (e.g., snacks, protein drinks, water). Food is limited to \$10 per person and must be used in the course of service engagement.

The following are supplies and services that **CANNOT be supported with SAMHSA funding**:

- **No federal funding** can be used directly or through subsequent reimbursement of grantees to purchase pipes or other supplies for safer smoking kits nor syringes or needles used to inject illicit drugs. Grant funds cannot be used to purchase any other drug paraphernalia.
- Sterile water, saline, or ascorbic acid (vitamin c) used to facilitate drug use.
- Any other supplies to promote or facilitate drug use not listed as acceptable above.

SAMHSA is committed to being a partner with you in these efforts by providing funding, technical assistance, subject matter expertise, and [best-practice resources](#) to help individuals, families, and communities support optimal OORM distribution, training, and use.

To finally bring an end to the overdose crisis and Make America Healthy Again, we have to zero in on common-sense public health approaches that focus on prevention, treatment, and long-term recovery. This includes:

- Advancing community and school-based substance misuse prevention to prevent drug use in the first place;

- Expanding access to evidence-based treatment for substance use disorders, including medications for opioid use disorder;
- Enhancing use of recovery support services, including peers, recovery coaches, recovery housing and recovery community organizations to help people achieve long-term recovery;
- Raising awareness about the toxic drug supply and the risk of drug use to individuals, families, and communities; and
- Increasing distribution, training, and use of OORMs, naloxone and nalmefene, to save lives and connect people to treatment.

We also know there is a tremendous amount of innovation that is happening in this space – whether it is innovating with data and community saturation or braiding and blending funding streams or creating new partnerships to address overdose and the infectious disease consequences linked to drug use, mental illness and homelessness – states have experiences and best practices that can be shared to help others innovate. I invite you to continue sharing your successes, your innovations, and your challenges with us and with your state colleagues.

SAMHSA remains dedicated to equipping state partners with the tools necessary to save lives, so that people can recover and improve their quality of life. Thank you for your partnership and collaboration, and we look forward to our continued focused work to save lives.

Sincerely,
/Art Kleinschmidt/

Art Kleinschmidt, Ph.D., MBA
Principal Deputy Assistant Secretary
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Behavioral Health is Essential to Health • Prevention Works • Treatment is Effective • People Recover

Substance Abuse and Mental Health Services Administration
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
