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: VA-604 - Prince William County CoC

1A-2. Collaborative Applicant Name: Prince William County Department of Social Services

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Prince William County Department of Social Service

1B. Coordination and Engagement–Accountable Structure and Participation

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

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

1B-1.	Accountable Structure and Participation.	

	In the chart below for the period from June 1, 2025 to May 31, 2026:
1.	select 'Yes' or 'No' in the chart below if the entity listed participated in CoC meetings or select 'Nonexistent' if the entity does not exist in your CoC's geographic area, and
2.	enter the number of persons on the board for each category where you answered 'Yes' in the Participated in CoC Meetings column.

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

	Entity	Participated in CoC Meetings	Number of Board Members
1.	Affordable Housing Developer(s)	Yes	0
2.	CDBG/HOME/ESG Entitlement Jurisdiction(s)	Yes	0
3.	Certified Community Behavioral Health Clinic (CCBHC)	Yes	0
4.	Community Mental Health Center (CMHC)	Yes	0
5.	Disability Advocate(s)	No	
6.	Disability Service Organization(s)	No	
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	0
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	1
9.	Faith-based Organzation(s)	Yes	2
10.	Homeless or Formerly Homeless Person(s)	Yes	2
11.	Hospital(s)	Yes	0
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	0
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Nonexistent	
14.	Law Enforcement	Yes	0
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	0
16.	Local Government Staff/Official(s)	Yes	2

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

1B-2.	Open Invitation for New Members.	

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

(limit 2,500 characters)

The Prince William Area Continuum of Care (PWA CoC) maintains a transparent, publicly accessible process to solicit new membership at least annually. Each year, typically during May and June, the CoC conducts an open recruitment period to invite new members and confirm renewals from existing members. This opportunity is posted on the PWA CoC's website, along with information on how to join, membership expectations, and meeting schedules, so that any interested organization or individual can access it at any time, not only during the formal recruitment window. The CoC also distributes direct email invitations to known homeless service providers, mainstream housing and human service agencies, healthcare and behavioral health organizations, faith-based and community groups, local government representatives, law enforcement, businesses, and people with lived experience of homelessness, to ensure broad and diverse participation. In addition to digital outreach, the CoC's regular meetings are open to the public, allowing any interested party to attend, learn about the CoC's work, and request membership. The CoC further extends its reach by participating in community events such as the Community Outreach Fair, GovFest, the Procurement Expo, and relevant symposiums, where staff and members engage directly with residents and organizations that may not otherwise be aware of the CoC. Together, these year-round and annually renewed outreach efforts help ensure that CoC membership reflects the full diversity of the Prince William Area's population and provider community, strengthening the CoC's capacity to plan for and respond to homelessness.

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

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

(limit 2,500 characters)

The PWA CoC maintains a transparent, ongoing process to solicit and consider input on the CoC's general performance, strategies, and priority-setting from a broad array of individuals and organizations knowledgeable about or invested in preventing and ending homelessness across the CoC's geographic area, which includes Prince William County, the City of Manassas, and the City of Manassas Park. The CoC gathers this input primarily through monthly committee and workgroup meetings, which are open to stakeholders across sectors and are announced publicly on the CoC's website along with meeting schedules and agendas. To reach organizations with specialized knowledge of homelessness, the CoC holds dedicated meetings with agencies such as Probation & Parole, the Sheriff's Office, Police, the Public Defender's Office, the Office of Community Safety, Community Engagement, Criminal Justice partners, and Public Health, ensuring perspectives from the justice and public health systems inform CoC planning. The CoC also proactively solicits new partners, including agencies identified through community events such as GovFest and Procurement Expo to expand the range of voices contributing feedback. Beyond these targeted efforts, the CoC regularly engages broader community bodies, including the Chamber of Commerce, the Veterans Commission, the Cooperative Council of Ministries, and the DSS Advisory Board, gathering their input through public forums and standing meetings. To ensure input is captured systematically and from those unable to attend in person, the CoC utilizes the Civic Roundtable platform to collect ongoing feedback on CoC policies, procedures, prioritization decisions, and training needs, and uses live polling tools such as Mentimeter during policy development and workgroup sessions to capture real-time opinions from all participants. Together, these methods ensure the CoC's strategies and priorities are shaped by a wide, representative range of stakeholders, including those with lived experience, direct service providers, government partners, and the broader community, across all three jurisdictions in the CoC's geographic area.

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

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

(limit 2,500 characters)

The PWA CoC invites new project proposals from any eligible entity, including faith-based organizations, through an open and transparent application process. Direct outreach is conducted via email to the Resource Roundtable, a group of non-profit and faith-based organizations, the Cooperative Council of Ministries (CCOM), a network of local churches, and the Human Services Alliance of Greater Prince William among other community and faith-based partners. The CoC's Request for Proposals (RFP) was released on June 17, 2026 on the CoC's website and disseminated widely via email to stakeholders, Metropolitan Washington Council of Governments (COG) listservs, social media, surrounding CoCs, and community calendars. The RFP specifically encourages applications from organizations that have not previously received CoC Program funding, in order to enhance the diversity of providers within the CoC. A "How to Apply" workshop was held on June 22, 2026 to further support new project applicants by explaining the application process and encouraging attendees to apply and share the funding opportunity with other interested organizations.

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

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

(limit 2,500 characters)

Gap Identified: FY2026 APR data (7/1/2025-6/30/2026) for emergency shelter, street outreach, and transitional housing identified 160 non-veteran persons experiencing chronic homelessness. Of the CoC's 194 year-round PSH beds, 150 (77%) are VASH beds dedicated to veterans, leaving only 44 (23%) for non-veterans. In FY2026, 18 non-veterans were referred to PSH and 8 were housed. Provider feedback from CoC case conferencing confirms limited non-veteran PSH capacity is a persistent barrier to housing the community's highest-need, longest-homeless individuals.

Strategy: The CoC will expand interventions for non-veteran chronically homeless individuals while pursuing more PSH capacity. Consistent with FY2026 NOFO priorities, the CoC will solicit a new Transitional Housing (TH) project to bridge individuals awaiting PSH to permanent housing, and a new Supportive Services Only (SSO) project for case management, housing navigation, stabilization, and move-on support. The CoC will formalize PSH move-on assessments so participants ready for less intensive housing can transition, freeing units for higher-need individuals, and will evaluate reallocation and other funding to expand non-veteran PSH. Existing coordinated entry policies and dedicated resources for veterans, families with children, youth, and DV survivors will remain in place.

Performance Measures: (1) Submit one new TH and one new SSO project application in the FY2027 CoC Program Competition; (2) complete move-on assessments for 100% of eligible PSH participants annually; (3) track successful move-on transitions and PSH units made available for higher-need households; (4) track housing outcomes for individuals served through the new TH and SSO projects.

Timeline: Release the new-project RFP within 90 days of NOFO award; complete PAR review and selection within 150 days; implement move-on assessments within 180 days; report implementation and year-one performance to the CoC At-Large within 12 months.

Funding: FY2026 CoC Program new-project funding for TH and SSO; Virginia DHCD and SRAP funds administered through Prince William County OHCD for eligible move-on and supportive services.

Oversight: The PAR Committee, with the Governance Committee, will oversee implementation and report progress quarterly to the CoC At-Large.

1B-5a	Confirmation of Plan Coverage.

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

1. Identifies the gap, using data or stakeholder feedback	Yes
2. The strategy to address the needs of all relevant subpopulations	Yes
3. Sets quantifiable performance measures	Yes
4. Identifies timelines for the completion of specific tasks	Yes
5. Identifies specific funding sources for planned activities	Yes
6. An individual or body responsible for overseeing implementation of specific strategies	Yes

1C. Coordination and Engagement

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- Frequently Asked Questions

1C-1.	**Treatment and Recovery Services—On-site Substance Use Treatment Availability.**	
	You must upload the List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment attachment to the 4A. Attachments Screen.	
	What percent of your TH/RRH/PSH projects have substance use treatment available on site?	33%

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)

VA-604 is not a rural CoC.

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 Prince William County Community Services (CS), the local Community Services Board, and Lunera Health, a community health center with three local sites, to connect people experiencing homelessness to outpatient mental health and substance use disorder (SUD) treatment.

Levels of care: CS provides assessment, psychiatric evaluation, individual and group therapy, and outpatient and intensive outpatient SUD treatment, with fees based on ability to pay. For adults with serious mental illness best served in the community, CS's Assertive Community Treatment (ACT) team delivers the most intensive outpatient level: a multidisciplinary team provides psychiatric, nursing, therapy, SUD, and peer services outside the clinic, seven days a week, to help clients reach and maintain their maximum independence. Lunera integrates behavioral health with primary care, offering counseling, outpatient SUD counseling, and psychiatric services in English, Spanish, French, and Creole. StreetLight's PSH program links participants to detox and SUD treatment through BrightView Health, National Capital Treatment & Recovery, and Warsaw Recovery Center. Participants step up or down in care as needs change while keeping their housing.

Psychosocial interventions: CS and Lunera clinicians build individualized treatment plans at intake. StreetLight's Clinical Health & Wellness Case Manager coordinates appointments, builds health literacy, and helps participants stay engaged in care.

Medication management: CS provides medication management, including [medication-assisted treatment], and the ACT team provides medication management in the community. Lunera provides psychiatric services, and its sliding fee scale and Medicaid enrollment help keep uninsured participants in treatment.

Suicide prevention: The CoC coordinates with the PWC Crisis Receiving Center Complex for suicide risk screening, safety planning, and follow-up referrals, and directs anyone at immediate risk to 988.

Recovery supports: CS peer recovery specialists, NAMI, the PWC Adult Drug Recovery Court, Veterans Treatment Docket, and DORS help participants sustain recovery alongside housing goals.

Coordination: The CS PATH program and CoC street outreach teams engage unsheltered people with serious mental illness and make warm referrals to CS, ACT, and Lunera. Behavioral health partners join CoC committees and By-Name List case conferencing to support warm hand offs.

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 partners with Prince William County Community Services (CS) to give people experiencing homelessness access to peer recovery specialists and recovery navigation, including through the Peer Support and Recovery Support Services programs co-located at the Crisis Receiving Center (CRC). Peer Recovery Specialists work alongside CoC case managers to help participants engage in treatment, build recovery capital, and sustain the skills needed to keep stable housing.

Peer Recovery Specialists are also embedded in CS's Recovery Support Services Medication Assisted Treatment (MAT) Clinic at two locations, the Ferlazzo Center in Woodbridge and Sudley-North in Manassas, giving CoC participants peer support alongside clinical MAT and harm reduction services. Peer staff provide one-on-one recovery coaching, connection to outpatient treatment and support groups, help navigating relapse and crisis, and modeling of recovery skills based on lived experience, using a harm reduction, person-centered approach.

Access: CoC street outreach teams, the CS PATH program, shelters, and Coordinated Entry make warm referrals to peer services. Participants in crisis are connected to CRC peer staff, who help them move from crisis care into ongoing treatment and recovery support.

Coordination: CoC case managers and Peer Recovery Specialists coordinate [frequency, e.g., weekly; method, e.g., case consultation] and through By-Name List case conferencing so participants receive consistent, wraparound support that addresses both housing stability and recovery goals.

Recovery navigation in CoC projects: StreetLight's PSH program adds a Clinical Health & Wellness Case Manager who helps participants navigate care, coordinate appointments, and follow through on treatment, including SUD treatment and detox. Participants are also connected to NAMI [confirm peer programs] and community support groups to build natural supports that last beyond program participation.

Through these partnerships, people experiencing homelessness who are navigating substance use or co-occurring disorders have peer-based support that complements clinical treatment and strengthens long-term housing retention.

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

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

(limit 2,500 characters)

The CoC identifies individuals experiencing Serious Mental Illness (SMI) at every system entry point. Street outreach, including Prince William County Community Services' (CS) SAMHSA-funded PATH team, engages people in shelters, drop-in centers, the mobile unit, and encampments and screens for SMI and co-occurring disorders. Coordinated Entry uses the MAP Assessment (launched Oct. 2025, replacing the VI-SPDAT), and HMIS disabling-condition data feed the community-wide By-Name List, where regular case conferencing flags persons with SMI for prioritization and clinical linkage. Other identification points include the Crisis Receiving Center (CRC), jail booking, where every person receives a validated mental health screen under the County's Stepping Up initiative, and hospital discharge planning. Need is significant: in the 2026 PIT, 50% of adults reported a disabling condition, 41% a mental health disorder, and chronic homelessness rose to 30% of adults.

Once identified, individuals are connected to a continuum of intensive services. CS operates an Assertive Community Treatment (ACT) team, expanded through a SAMHSA ACT grant, that delivers multidisciplinary care in the community: psychiatric treatment and medication management, nursing, co-occurring SUD treatment, mobile crisis intervention, employment support, and direct help securing and keeping housing. For those needing less intensity, CS Supported Living Services provides community case management and skill-building, and Clinical Homeless Services serves people with mental illness not meeting SMI criteria. A DBHDS-funded PSH initiative pairs housing assistance with mental health case managers and a peer outreach specialist, accepting referrals from shelters, campsites, the jail, and psychiatric facilities. CoC-funded PSH serves chronically homeless adults with SMI. The 24/7 CRC, operated by Connections Health Solutions, offers walk-in care, 23-hour observation, and crisis stabilization beds, with warm hand-offs to CS for follow-up. Trillium Drop-In Center's certified Peer Recovery Specialists provide ongoing peer support.

PATH and ACT staff participate in CoC case conferencing so housing and treatment plans are aligned, and engagement continues after housing placement to promote long-term stability.

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 partners with PWC Criminal Justice Services' Adult Recovery Court and the Greater Prince William Veterans Treatment Docket, which serve people with substance use and co-occurring mental health disorders, and with OAR and DOC District 35 Probation & Parole. PWC Community Services, the local CSB, provides Drug Offenders Recovery Services (DORS) to court-involved clients, prescreens for inpatient civil commitment, and monitors court-ordered Assisted Outpatient Treatment (AOT).

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 with two 31st Judicial Circuit specialty courts: the Veterans Treatment Docket (VTD) and the Adult Recovery Court (ARC). Both serve high-need participants with substance use and mental health disorders, working with court partners including the Community Services Board (CSB), District 35 Probation and Parole, and PWC Criminal Justice Services.

The VTD serves high-need Veterans whose participation contract and court order require them to enter and remain in treatment. Securing housing is a formal Phase Goal, so as part of probation and case management each Veteran must work toward stable housing to advance in the program. The VTD Probation Officer coordinates directly with the VA, the Virginia Department of Veterans Services (DVS), the CoC's Coordinated Entry System (CES), and other nonprofits to secure emergency housing while permanent options are identified. Through CES, Veterans complete the MAP assessment and are added to the CoC's Veteran By-Name List, linking them to VA, SSVF, and CoC housing resources. ARC follows the same model: stable housing is a required element of its five-phase program, and the court team refers participants experiencing homelessness to CES.

The CoC leverages court orders by treating them as the participant's stability plan. Court-ordered treatment, supervision, and phase goals give housing providers and the court team one shared set of expectations. With signed releases, case managers and probation share progress so housing plans reinforce court requirements rather than duplicate them. Because advancing through phases depends on housing, participants have a clear incentive to pursue it. Because completing the program can reduce or dismiss charges, the court also removes a lasting barrier to housing and employment.

As participants progress, service intensity steps down while they are connected to employment, benefits, VA health care, and peer recovery supports, so housing is sustained after court supervision ends.

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 the PWC Crisis Receiving Center (CRC), operated by Connections Health Solutions with PWC Community Services (CS). Open since Oct. 2025, with 24/7/365 walk-in care since Jan. 2026, the CRC offers 23-hour observation, crisis stabilization (16 adult/16 youth beds), and withdrawal management, and receives calls from the 988 Regional Crisis Call Line and CS mobile crisis teams. CES staff refer people in crisis to the CRC, which makes warm hand-offs back to CS and CoC providers.

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.	25

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 Prince William County Community Services (CS), the local public mental health center, and its SAMHSA PATH program, funded through the Virginia Department of Behavioral Health and Developmental Services. CS is a CoC member that actively participates in Service Continuum. PATH staff serve homeless adults with serious mental illness and co-occurring disorders through outreach in shelters and camps, screening, case management, and linkage to care.

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)

SLS Home Solutions' new 10-bed Transitional Housing project, proposed in the FY 2026 CoC competition, will operate as sober housing under 24 CFR 578.93(b)(5), maintaining a safe, respectful, and substance-free living environment. The project meets a CoC-identified need: reported substance use disorders rose 57% in the 2026 PIT. Residents receive case management, housing navigation, and referrals to treatment.

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

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

(limit 2,500 characters)

The CoC coordinates warm hand-offs between behavioral health, substance use treatment, crisis, and justice partners and CoC housing providers through Coordinated Entry (CES), By-Name List (BNL) case conferencing, and joint participation in CoC committees, including the Service Continuum. Referral before discharge: When a partner identifies someone who is homeless or at risk, staff connect the person to CES before discharge rather than releasing them without a housing plan. CES staff complete the MAP Assessment, which replaced the VI-SPDAT in October 2025, and screen first for prevention and diversion, such as family reunification, landlord mediation, or financial assistance, so people who can safely avoid shelter never enter it. Those who cannot be diverted are added to the BNL and prioritized for housing.

Crisis and inpatient exits: The 24/7 Crisis Receiving Center (CRC) builds warm hand-offs into its discharge planning, connecting people leaving 23-hour observation or crisis stabilization to Community Services (CS) follow-up. For those without stable housing, CS links them to CES and to the CS PATH team, which stays engaged until housing is secured. CS's DBHDS-funded Permanent Supportive Housing initiative accepts referrals directly from psychiatric facilities, the jail, shelters, and campsites.

Treatment and recovery: ACT and Supported Living Services staff keep treating participants after housing placement, so treatment continues across the transition. Peer Recovery Specialists at the Trillium Drop-In Center provide ongoing peer support. For people leaving treatment who want a recovery-focused setting, the CoC's proposed SLS Home Solutions sober Transitional Housing project will offer a structured, substance-free bridge to permanent housing.

Justice-involved participants: Adult Recovery Court and Veterans Treatment Docket teams, DORS counselors at the Adult Detention Center, and Probation & Parole officers refer participants to CES before release or program completion. Veterans are also connected to VA housing resources through the Veteran BNL.

Accountability: PATH, ACT, and CoC housing case managers review shared clients at BNL case conferencing, confirm each referral was received, and track housing outcomes in HMIS. This closes gaps where people could fall back into homelessness. The CoC reviews returns to homelessness through System Performance Measure 2 and uses these results to refine hand-off procedures.

1C-2.	Supportive Services Investment.		

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	$1,786,420
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.	$990,467
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	55%
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.	$247,000

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).	69%

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)

The CoC consults with two ESG recipients. The first is Prince William County's Office of Housing and Community Development (OHCD), the urban county ESG recipient that administers CDBG, HOME, and ESG for the Prince William Area. The second is the Virginia Department of Housing and Community Development (DHCD), the state ESG recipient, which awards state ESG through the Virginia Homeless Solutions Program (VHSP).

Planning: OHCD staff attend CoC and Service Continuum Committee meetings and take part in the annual Point-in-Time (PIT) count. In these meetings, OHCD hears CoC priorities, system gaps, and By-Name List trends directly from providers and people with lived experience. The CoC gives OHCD PIT, Housing Inventory Count (HIC), HMIS, and System Performance Measure data for the Consolidated Plan, Annual Action Plans, and CAPER. CoC members also comment on these plans during public comment periods, so local homeless needs shape ESG goals.

Allocation: OHCD awards ESG to CoC member agencies for shelter operations, street outreach, and rapid re-housing, based on needs the CoC identifies. The CoC helps align these awards with CoC Program priorities so ESG and CoC funds complement each other rather than duplicate. ESG-funded projects take referrals through Coordinated Entry. For state ESG, the CoC lead coordinates the community's VHSP application with DHCD, and CoC partners jointly set local priorities for prevention, shelter, outreach, and RRH funding.

Performance: All ESG-funded projects enter data in the CoC's HMIS and follow CoC written standards and Coordinated Entry policies. The CoC shares ESG project performance data with OHCD and DHCD to inform funding decisions.

Going forward: The CoC will keep OHCD engaged through standing committee participation. Each year it will provide PIT, HIC, and SPM data for Consolidated Plan and Action Plan updates. It will use its Built for Zero goals, including street outreach expansion and system-wide prioritization, to recommend where ESG funds should go. The CoC will also invite OHCD to review CoC priorities during the annual local competition, so ESG and CoC Program funds are planned as one system.

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 emergency shelter providers, including the Ferlazzo Emergency Shelter, Hilda Barg Homeless Prevention Center, Supportive Shelter, Beverly Warren, SERVE, and the ACTS DV Shelter, through the Coordinated Entry System (CES) and the community-wide By-Name List (BNL).

Single front door: CES operates a coordinated call center (703-792-3366), Monday through Friday, 8:30 a.m. to 5:30 p.m., as the front door for shelter referrals. CES completes an initial assessment and first-level screening, including diversion to help households safely avoid shelter when possible, while shelter providers retain final admission decisions. CES also uses a standardized Activities of Daily Living (ADL) assessment at shelter entry so each person is matched to a shelter that can meet their mobility, personal care, and medication needs.

Real-time bed matching: Shelter providers use HMIS for referrals and must post bed vacancies within 24 hours, so CES staff can match households to open beds in real time. The ACTS DV Shelter uses an HMIS-comparable database to protect survivor confidentiality, and CES coordinates DV referrals through confidential, de-identified processes.

Connection to CoC assistance: Once in shelter, participants complete the MAP Assessment, which replaced the VI-SPDAT in October 2025. The assessment determines priority and the best-fit CoC intervention, such as Rapid Re-Housing, Permanent Supportive Housing, or Transitional Housing. Shelter case managers work with participants on housing plans and on gathering identification, income verification, and other documents in advance, so households are ready when a unit becomes available. Reducing documentation barriers is one of the CoC's five Built for Zero priority goals for 2026.

Case conferencing: Shelter providers participate in BNL review meetings on the second and fourth Tuesday of each month and in Community Case Conferencing on the first and third Friday. At these meetings, providers review every sheltered household by name, resolve barriers, and confirm referrals to CoC housing so no one stays in shelter without an active housing pathway.

Seasonal capacity: During winter, the CoC coordinates with hypothermia shelter partners. In 2026 it added 34 hypothermia beds, contributing to a 30% drop in unsheltered homelessness. CES and outreach staff connect guests in these beds to the same assessment and BNL process.

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 PIT, HIC, HMIS, and System Performance Measure (SPM) data with state and local government partners, including Prince William County, the Cities of Manassas and Manassas Park, the Virginia Department of Housing and Community Development (DHCD), and other relevant state agencies, consistent with applicable law and the CoC's HMIS Privacy and Security Plans, which the CoC reviews annually. The CoC also participates in DHCD's Homeless Data Integration Project (HDIP), which integrates local HMIS data for statewide planning, analysis, reporting, and coordination of services. PIT and HIC data are also shared with the Metropolitan Washington Council of Governments for its annual regional homelessness report, and the CoC publishes a jurisdictional narrative with each count.

The CoC uses aggregate and appropriately protected data to inform community planning, resource allocation, program and system performance, funding decisions, and strategies to prevent and end homelessness. Data is shared through various system- and project-level reports, including the HUD PIT and SPM reports, the CoC's Annual Community Report and Provider Report Card, approved data requests, and presentations to the Board of County Supervisors and CoC committees. The CoC also maintains public dashboards on the County website, including a Community Performance Dashboard showing SPM outcomes, most of which are updated monthly.

The HMIS Lead reviews data requests to determine whether and how information may be provided under applicable requirements, including the purpose, scope, populations, programs, and types of information requested. Approved disclosures are limited to information reasonably necessary for the authorized purpose and are documented, including the applicable authorization or legal basis. Client-level or personally identifiable information is not released to external entities unless specifically authorized and permitted by applicable requirements.

This approach allows government partners to access information needed to understand and strengthen the homelessness response system while protecting client privacy and confidentiality.

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 does not currently have formal data-sharing agreements that integrate health care claims data, electronic health record data, admission/discharge/transfer data, or law enforcement and corrections system data with HMIS. The CoC does, however, use information from other systems through established partnerships and state initiatives to complement HMIS data and improve care.

State data integration: The CoC contributes HMIS data to the Virginia Department of Housing and Community Development's Homeless Data Integration Project (HDIP). State partners have used HDIP to match Medicaid and Community Services Board data with HMIS to identify people who use multiple systems and to inform supportive housing investments.

Behavioral health and corrections: Prince William County agencies use a shared definition of serious mental illness across the local criminal justice and behavioral health systems, and every person booked into the Adult Detention Center receives a validated mental health screen. Community Services and CoC partners use this information, along with Crisis Receiving Center utilization and discharge trends, to identify people with behavioral health needs who are at risk of homelessness and to plan services.

Community partnerships: Partners include local hospitals, the George Mason University MAP Clinic, the Greater Prince William Health Center, Prince William County Community Services, Police, Fire & Rescue, and the Office of Community Safety. Representatives from these systems participate in CoC committees and other collaborative initiatives, supporting ongoing coordination and information sharing. Information shared through these partnerships, including overdose and public drug use trends and other emerging community needs, complements HMIS data and helps inform provider coordination, service planning, outreach, and connections to health and supportive services.

Next steps: Formalizing broader cross-system data sharing is an identified area for improvement. Over the next 12 months, the CoC will explore data sharing agreements with local hospitals for discharge notifications and with the Adult Detention Center for release planning, consistent with the CoC's HMIS Privacy and Security Plans.

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 Virginia Career Works (VCW)-Northern, the Local Workforce Development Board (LWDB) for Northern Virginia, and its Prince William Center in Woodbridge, a comprehensive American Job Center (One-Stop Career Center). Funded through the Workforce Innovation and Opportunity Act (WIOA), the Center provides free career coaching, resume and job-search assistance, job placement, and WIOA-funded occupational training for adults, dislocated workers, and youth.

The partnership connects CoC participants to employment in five ways:

1) Coordinated referrals. Coordinated Entry (CES) staff and CoC-funded providers assess every household's employment and income needs at intake and throughout housing stabilization. Participants seeking work are referred directly to VCW career services and training.
2) System-wide access. VCW is listed in the CoC Community Resource Guide used at shelters, the Bill Mehr Drop-In Center, and CES, so people experiencing homelessness learn about free workforce services at their first point of contact.
3) Veterans. VCW's on-site Veterans Employment Representatives work with the CoC's veteran-serving partners to connect homeless and at-risk veterans to jobs and career pathways.
4) Job readiness and financial capability. CoC providers work with VCW and Virginia Cooperative Extension to deliver job-readiness, job-skills, and financial literacy training that helps participants increase earned income and sustain housing.
5) Joint planning: VCW attends CoC meetings and is actively engaged with the CoC providers on referrals and services.
Through this partnership, the CoC pairs housing assistance with employment services to increase earned income among participants in CoC-funded projects, advancing System Performance Measure 4 and long-term housing stability.

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 Homeless Services Division (HSD) leads street outreach with Community Services (CS) PATH and Streetlight Ministries, covering Prince William County's 348 square miles and the Cities of Manassas and Manassas Park. Together they engage people experiencing homelessness and connect them to CoC services and housing.

Cooperation with law enforcement: HSD works closely with the Police Department (PD) on encampments, unsafe locations, and other situations requiring coordinated engagement. When an encampment is identified, police may notify HSD directly. When a property owner requests removal of individuals from private property, police help post and confirm required notices before HSD engages individuals, giving outreach staff time to make contact, explain available services, and encourage connection to CoC resources. PD provides follow-up until the location is closed and may coordinate with the Office of Community Safety when an encampment affects a business or neighborhood. This balances community safety with meaningful opportunities to access services.

Unsafe locations and panhandling: When police identify a location that may be unsafe for outreach staff, they coordinate with HSD, CS, and the Office of Community Safety on a safe way to engage individuals. Police also notify HSD of panhandling locations so outreach staff can offer information and services.

Co-response and crisis: Through Virginia's Marcus Alert system, six co-responder teams pairing a CS mental health professional with a Crisis Intervention Team-trained officer respond to behavioral health calls, and an Outreach and Engagement Team follows up on referrals from police and Fire & Rescue Officers can bring people directly to the 24/7 Crisis Receiving Center through its first-responder entrance, and the CRC and PATH team link those without housing to Coordinated Entry. Fire & Rescue/EMS notify HSD of frequent callers experiencing homelessness.

Building positive interactions: PD supports outreach beyond enforcement. Officers, Sheriff's deputies, and Park Rangers assist outreach teams during the annual Point-in-Time Count, reaching areas staff cannot safely access alone, and outreach staff shadow road calls and join ride-alongs. These activities build trust, improve communication, and clarify each agency's role, so interactions with first responders become pathways to CoC services and housing rather than enforcement alone.

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 PWA CoC and its recipients treat family and support-network reunification as a housing solution at every stage, from first contact through CoC-funded housing.

Identifying supports early: When households contact Coordinated Entry (CES), staff hold a diversion conversation to identify family members, friends, or other natural supports who may be able to offer safe, stable housing, so some households never need to enter shelter. Outreach workers, shelter case managers, and CoC-funded housing case managers continue this exploration throughout a person's stay, and potential reunification options are discussed during By-Name List case conferencing.

Planning a safe reunification: Before any reunification, case managers confirm with the receiving family member or support that they are willing and able to provide housing, and they discuss expectations such as length of stay, household rules, and shared costs. Case managers also screen for safety, including domestic violence and other risks, so no one is returned to an unsafe situation. Survivors are supported by victim service providers to identify safe supports.

Travel and financial assistance: When reunification requires moving to another geographic area, recipients help with travel costs such as bus or train tickets, and may provide related assistance like identification documents, medication supplies, or a small contribution toward household costs where funding allows.

Arranging assistance in the receiving community: Case managers coordinate with service providers, CoCs, and mainstream agencies in the receiving area to arrange a warm hand-off, such as behavioral health services, benefits transfers, or local case management, so support continues after arrival. Staff follow up after the move to confirm the person arrived and the arrangement is stable.

Reunifying households within the system: Case managers also reunify family members who are in separate programs, such as couples or parents and adult children placed in different shelters, by coordinating referrals so they can enter a housing program together.

Mediation to preserve existing supports: Case managers mediate conflicts with family members, roommates, or landlords to help people keep an existing living arrangement and avoid entering or returning to homelessness.

Exits to family or friends are recorded in HMIS, allowing the CoC to monitor reunification outcomes and returns to homelessness.

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 the Prince William County Police Department (PWC PD), the Office of Community Safety, Neighborhood Services, and Community Services (CS), and does not interfere with or impede local efforts to protect public safety. The CoC's role is to engage people experiencing homelessness and connect them to shelter, outreach, behavioral health and substance use treatment, and housing.

Clearing tents and encampments: Street outreach providers work with PWC PD and Neighborhood Services when an encampment is scheduled for closure. The County follows a 30-day process that gives outreach staff time to engage residents, explain services, and connect them to shelter and housing. At the end of 30 days, PWC PD ensures individuals have moved and, if needed, takes appropriate trespass enforcement steps, while Neighborhood Services and PWC PD work with property owners to complete the closure. Outreach does not delay or obstruct closures.

Decreasing public illicit drug use: The CS PATH team and outreach partners engage people using substances in public and connect them to CS treatment, including Drug Offenders Recovery Services, peer recovery support, and withdrawal management at the 24/7 Crisis Receiving Center (CRC). The CoC also worked with CS to provide naloxone training and supplies to outreach staff and PIT volunteers.

Danger to self or others: The CoC supports Virginia's emergency custody and temporary detention process. CS emergency services staff conduct prescreening for involuntary commitment, and police can bring individuals, including those under a temporary detention order, directly to the CRC's first-responder entrance, reducing out-of-area hospital placements. Outreach staff contact police or CS mobile crisis when someone poses an immediate risk.

SORNA: The CoC cooperates with law enforcement on sex offender registry requirements and does not impede information sharing permitted under SORNA and Virginia law. Shelter providers check the Virginia Sex Offender Registry at intake and share information with PWC PD as permitted.

Assisting first responders: Police notify HSD of encampments, unsafe locations, and panhandling so outreach can respond, and CES and PATH link people referred by first responders to housing, reducing repeat law enforcement contacts.

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)

Helpful policies: The CoC leverages Prince William County's Trespassing Enforcement Program (County Code §§16-41.1–16-41.4), which allows enrolled property owners to designate the Police Department to enforce trespassing laws on their behalf. The CoC pairs this authority with the County's 30-day encampment process, coordinated by Police, DSS Homeless Services, Community Services, the Office of Community Safety, Neighborhood Services, Streetlight Ministries, and the property owner. In Week 1, the team notifies residents of the 30-day deadline and offers DSS and Community Services resources. Police visit in Week 2. In Week 3, the team returns to notify additional residents and continue engagement. In Week 4, Police address anyone remaining under applicable law. Outreach staff connect residents to shelter, Coordinated Entry, housing, and behavioral health and substance use services throughout.

Limitations: The CoC has not identified a local law that hinders its ability to address encampments. In practice, however, enforcement depends on property owners initiating the process, and people who leave one site may relocate to another, where they must be re-engaged.

Data: Community Outreach Survey submissions reporting unsheltered locations declined 51%, from 35 in FY2025 to 17 in FY2026. People served by street outreach rose 32%, from 407 to 539, while SPM 5.2 showed only a 2% increase in newly homeless persons, suggesting greater outreach reach rather than more homelessness. The 2026 PIT count found 30% fewer unsheltered persons, supported by 34 added hypothermia beds.

Plan: Over the next 12 months, the CoC will (1) expand outreach coverage by assigning workers to geographic zones under its Built for Zero Street Outreach Expansion goal; (2) use the Community Outreach Survey and GIS mapping to find new sites early, before they grow; (3) track every encampment resident on the By-Name List so people who relocate stay connected to the same worker; and (4) share closure outcomes with Police and the Office of Community Safety at monthly outreach coordination meetings. The Homeless Services Division will oversee implementation.

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

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

(limit 2,500 characters)

The CoC actively monitors tents and encampments through coordinated outreach, community reporting, and GIS mapping. As of September 2026, the CoC identifies 13 established encampments across Prince William County and the Cities of Manassas and Manassas Park. Because tents are frequently moved, added, or removed, the CoC tracks encampment locations and the people living in them rather than a fixed tent count.

Scale of unsheltered homelessness: The 2026 PIT count found unsheltered homelessness decreased 30% (34 fewer persons) from 2025, helped by 34 added hypothermia shelter beds. Needs among those remaining outside are high: 34% of unsheltered adults were chronically homeless, and 27% of those with a disabling condition reported three or more. Community Outreach Survey reports of unsheltered locations fell 51%, from 35 in FY2025 to 17 in FY2026, while people served by street outreach rose 32%, from 407 to 539.

Identification: New or changing encampments are reported through 311, the Prince William County Police Department, street outreach providers, the public Community Outreach Survey, and community members, allowing the CoC to respond quickly to new sites and monitor changes at existing ones.

Engagement: The Homeless Services Division (HSD) visits known encampments weekly to identify residents, assess immediate needs, share resources, and connect people to Coordinated Entry, shelter, and housing. Community Services' PATH team engages residents with mental health or substance use needs and links them to behavioral health treatment. Encampment residents are tracked on the By-Name List so they remain connected to housing opportunities.

GIS tracking: The CoC maps encampment locations in GIS as they are reported, updates them as conditions change, and removes locations once an encampment is no longer present. This gives the CoC a current picture of encampments and supports efficient deployment of outreach staff.

Goal: The CoC aims to reduce the number of encampments by 20% each year, from 13 to no more than 10 by September 2027, through weekly outreach, coordinated reporting, GIS tracking, and connections to housing and supportive services.

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)

Helpful policies and practices: Virginia's Marcus Alert law, implemented locally by Community Services (CS) and the Police Department (PD), establishes a specialized behavioral health response to crises involving mental health or substance use. Locally, six co-responder teams pair a mental health professional with a Crisis Intervention Team-trained officer, and 911 dispatches them when available. An Outreach and Engagement Team follows up on referrals from law enforcement and Fire & Rescue. The 24/7 Crisis Receiving Center (CRC) accepts people brought by police, including under temporary detention orders, and offers withdrawal management. The Adult Recovery Court and Drug Offenders Recovery Services (DORS) link people charged with drug offenses to supervised treatment.

Outreach response: Street outreach providers and the CS PATH team engage people using drugs in public, assess needs, and connect them to CS treatment, peer recovery support, shelter, and Coordinated Entry. When there is an immediate safety risk, outreach contacts PD or a co-responder team. CS has trained outreach staff and PIT volunteers in naloxone use and supplied them with it.

Data: Reported substance use disorders among people experiencing homelessness rose 57% in the 2026 PIT count, confirming the need. Co-responder teams answered about 900 calls in their first 17 months and diverted 88% of people in crisis from custody. In its first 10 weeks, the CRC served 304 adults, 164 of whom needed crisis stabilization, and out-of-area placements fell from 43% to 4%.

Limitations: Co-responder teams are not always available, public drug use can result in arrest without a treatment connection, and outreach staff often lose contact with people after one encounter.

Plan: Over the next 12 months, the CoC will (1) work with CS and PD so outreach can request co-responder or Outreach and Engagement Team follow-up for people repeatedly observed using drugs in public; (2) ensure every outreach or police encounter with public drug use includes an offer of treatment through the CRC or CS, alongside any enforcement action; (3) track people with substance use needs on the By-Name List so outreach can re-engage them; and (4) expand naloxone distribution through outreach. The Homeless Services Division and CS will oversee implementation and report progress to the CoC.

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)

Overdoses and illicit drug use in the CoC's geographic area (Prince William County and the Cities of Manassas and Manassas Park) are declining.

Overdoses: The Virginia Department of Health (VDH) reported 24 drug overdose deaths in Prince William County in 2025. This follows a sharp decline from the pandemic peak. The Prince William Health District's 2024 Opioid Needs Assessment documented 454 opioid-related deaths in the Greater Prince William region from 2018-2023, with the highest counts in 2020-2021. Statewide, VDH reports overdose deaths fell 37% in 2024 and a preliminary 23% in 2025. Nonfatal overdoses remain a concern: the Health District reported more than 300 nonfatal opioid overdoses per year since 2020, with rising rates among young adults ages 20-24. [Insert Fire & Rescue data: overdose calls and naloxone administrations, 2025 vs. 2024.]

Illicit drug use and enforcement: The Prince William County Police Department's 2025 annual report shows drug violations fell 8.1% (1,169 to 1,074) and drug equipment violations fell 48.6% (74 to 38) from 2024. Police seized about 26,200 fentanyl pills in 2025. The Prince William Narcotics Task Force includes county, Manassas, and Manassas Park police.

Among people experiencing homelessness: In the 2026 Point-in-Time Count, 48 people reported a substance use disorder. When Homeless Services, Community Services (CSB), and Police respond to encampments, CSB staff offer substance use and mental health services on site and individuals receive the Coordinated Entry hotline.

The CoC will continue to monitor VDH, Police, and Fire & Rescue data to track overdoses and public drug use and target outreach where needed.

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)

Helpful laws and practices: Prince William County applies Virginia's Emergency Custody Order (ECO) and Temporary Detention Order (TDO) framework (Code of Virginia §§37.2-808 and 37.2-809) when a person experiencing homelessness meets the criteria for emergency behavioral health intervention. Police, the Sheriff's Office, and Community Services (CS) carry out this process together. Under Virginia's Marcus Alert law, six co-responder teams pair a CS mental health professional with a Crisis Intervention Team (CIT)-trained officer to assess people in the field. A multi-agency Mission Group of CS, first responders, 911 dispatch, magistrates, and hospitals guide how behavioral health calls are triaged. CS Emergency Services conducts prescreening for involuntary commitment, and the 24/7 Crisis Receiving Center (CRC) can safely serve people under a TDO, providing stabilization close to home as an alternative to hospitalization or arrest. CS also monitors court-ordered Mandatory Outpatient Treatment.

Data: Co-responder teams answered about 900 calls in their first 17 months, diverting 88% of people in crisis from custody. Since opening in October 2025, the CRC has cut out-of-area placements for people under ECOs and TDOs from 43% to 4%. In its first months, 91 people moved to short-term residential crisis care instead of inpatient hospitalization. In the 2026 PIT count, 41% of adults experiencing homelessness reported a mental health disorder.

Limitations: Virginia's commitment standard requires a substantial likelihood of serious harm in the near future, so people with serious untreated mental illness who do not meet it can decline care. Short ECO timeframes and limited co-responder availability can also restrict how quickly a person is assessed.

Plan: Over the next 12 months, the CoC will (1) train Homeless Services Division outreach staff on ECO/TDO criteria, when to call 911 or CS Emergency Services, and their duties as mandated reporters to Adult Protective Services; (2) have the CS PATH team and ACT team continue engaging people who do not meet commitment criteria; (3) coordinate CRC discharges with Coordinated Entry so no one leaves crisis care without a housing plan; and (4) review cases at By-Name List case conferencing. HSD and CS will oversee implementation.

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)

Helpful laws and policies: Virginia's Sex Offender and Crimes Against Minors Registry Act (Code of Virginia §9.1-900 et seq.), the state registry law that operates alongside SORNA, requires registrants to register with the Virginia State Police and the local law enforcement agency where they physically reside, and to update their address within three days of a change. The Prince William County Police Department and Sheriff's Office are responsible for registration, monitoring, and enforcement. The CoC's role is to cooperate and not impede that work. The registry is publicly searchable, so providers can verify registration status. Under §9.1-906.1, registrants entering an emergency shelter opened during a declared emergency must notify shelter security staff. All shelters serving families check the Virginia registry at intake.

The CoC's HMIS Privacy Notice, consistent with HUD's HMIS privacy standards, permits disclosure of client information, including location, to law enforcement when required by law, in response to a court order, subpoena, or warrant, or to prevent a serious threat to health or safety. Nothing in CoC policy restricts sharing information in accordance with SORNA. Under 24 CFR 578.93(b)(4), CoC housing serving families with children may exclude registered sex offenders.

Limitations: The main limitation is the lack of a written protocol for handling requests. Because law enforcement requests are infrequent, staff at different agencies may be unsure how to respond, which can delay information sharing. In addition, victim service providers cannot share client data under VAWA, and registrants without a fixed address can be difficult to locate.

Plan: Over the next 12 months, the CoC will (1) adopt a written protocol, reviewed with the County Attorney, for responding to SORNA-related law enforcement requests; (2) designate the HMIS Lead as the single point of contact for Police and Sheriff requests; (3) add SORNA-related disclosures to the HMIS Privacy Notice at its next annual review; (4) train shelter and outreach staff on the protocol; and (5) log all requests and response times to measure compliance.

1C-11. Outreach Strategy.

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

(limit 2,500 characters)

The CoC's outreach strategy covers its full geographic area (Prince William County, the City of Manassas, and the City of Manassas Park) through coordinated, routine, and targeted outreach. Street outreach is provided by the Homeless Services Division (HSD) Outreach team, Streetlight Ministries (SLM), and Prince William County Community Services (CS), including its PATH program.

Coverage is data-driven. The CoC tracks 13 established encampments and conducts routine outreach at each. A Community Outreach Survey and GIS map identify where people are staying, and providers are dividing the area into zip code-based zones assigned to specific outreach workers so no area goes uncovered. Outreach providers meet monthly to review coverage, identify gaps, and adjust assignments. Community members and partners can report new encampments or people in need through a hotline, a dedicated email, 311, or directly to the Street Outreach Coordinator, and staff follow up promptly.

To reach people not otherwise engaged in services, staff meet people where they are: at the Bill Mehr Drop-In Center, the Mobile Drop-In Center, and through the Panhandling Initiative. Staff make repeated, relationship-based contacts with people who initially decline help, and the annual Point-in-Time count is used to engage people in encampments, share resource information, and continue follow-up.

Everyone engaged is connected to Coordinated Entry and added to the CoC's One (Uniform) By-Name List, launched in 2025 as part of the regional Built for Zero initiative, so each person is known by name and tracked until housed. The CoC's Built for Zero Street Outreach Expansion goal commits the CoC to an outreach network that accounts for all people experiencing unsheltered homelessness and is regularly assessed.

Specialized partnerships extend reach to key subpopulations. CS engages people with serious mental illness and/or developmental disabilities and links them to treatment. Veterans are identified and placed on the Veteran By-Name List, with services coordinated through VOA, Friendship Place, Operation Renewed Hope Foundation SSVF, and the DC VA Medical Center.

Street outreach providers do not serve families with minor children, so when staff encounter a family they immediately connect it to Coordinated Entry for shelter and housing assistance, involving Child Protective Services only when there is a child safety concern.

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

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

		Written Agreement
1.	Child Care (including Child Care and Development Fund)	Yes
2.	Early Childhood Providers	Yes
3.	Early Head Start	Yes
4.	Home Visiting Program (including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	Yes
5.	Head Start	Yes
6.	Healthy Start	No
7.	Public Pre-K	No
8.	Tribal Home Visiting Program	No
	Other (limit 150 characters)	
9.		

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

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

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

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

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

(limit 2,500 characters)

The CoC's written policies for informing households of their eligibility for educational services are in the PWA CoC Policies and Procedures (P&P), which cover both Coordinated Entry (CES) and all CoC recipients and subrecipients. The P&P were last reviewed and approved by the full CoC on July 9, 2026, and are reviewed annually through the Service Continuum Committee. They are publicly available on the CoC's website.

The P&P assign clear responsibility at two points of contact:

At Coordinated Entry: CES representatives are "responsible for coordinating with your local school district(s), charter school(s), and CES in the following ways: ensure that all families with children and young adults who qualify in your area are informed about their educational rights and their eligibility for educational services and they receive those services."

At program entry: For recipients and subrecipients, "The Program Director and/or designee is responsible for: ensuring that all families with children and young adults participating in this project are informed about their educational rights and their eligibility for educational services at intake and as necessary thereafter."

How households are informed: At the CES assessment and again at program intake, staff explain the household's rights under Subtitle VII-B of the McKinney-Vento Homeless Assistance Act, as amended by the Every Student Succeeds Act, including the right to immediate school enrollment without the usual records, to remain in the school of origin, and to transportation. Staff provide written information on these rights and connect the household directly with the McKinney-Vento liaison for Prince William County Public Schools, Manassas City Public Schools, or Manassas Park City Schools. Staff revisit educational needs as circumstances change, such as a move or new school year.

Accountability: Every agency serving children and youth must designate a staff liaison to the local school divisions. CES representatives and provider staff are trained on these requirements annually and as needed by CoC representatives, so every household entering the system through any door is informed of its educational rights.

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)

Prince William County Department of Social Services (DSS) coordinates closely with its Child Protective Services (CPS) and foster care programs to assist youth transitioning from public systems of care and connect them to housing and supportive resources.

DSS maintains a direct referral pathway between the CPS-Ongoing Team and Office of Housing and Community Development. For eligible youth, the CPS-Ongoing Team coordinates referrals for Family Unification Program (FUP) vouchers with Housing, supporting a streamlined connection between child welfare services and housing assistance. DSS staff maintain clear and timely communication with the foster care unit to address housing needs and coordinate appropriate resources.

The Homeless Services Division (HSD) and foster care staff and prioritized cases together to identify housing needs, address barriers, and determine appropriate referrals. This collaboration allows staff to share relevant information, coordinate services, and respond quickly when youth or young adults are at risk of homelessness or require immediate housing stabilization.

Coordination extends beyond permanent housing resources. DSS maintains communication pathways to connect youth and families with emergency shelter, rental assistance, utility assistance, and other available community resources when immediate needs arise. Housing and child welfare staff communicate directly to facilitate referrals, clarify program requirements, and reduce delays in accessing assistance.

Through Coordinated Entry and ongoing collaboration with CPS and foster care staff, DSS can identify housing needs, connect eligible youth to available resources, and coordinate services across systems. This established relationship supports a more seamless transition from foster care and child welfare services to stable housing and helps reduce the risk of homelessness among youth transitioning from public systems of care.

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)

There are no HHS Runaway and Homeless Youth (RHY)-funded programs, including Street Outreach Programs, Basic Center Programs, Transitional Living Programs, or Maternity Group Homes, in the PWA CoC's geographic area of Prince William County, the City of Manassas, and the City of Manassas Park.

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)

Dawson Beach Transitional Housing, operated by [operator], primarily serves families with children experiencing homelessness in accordance with 24 CFR 578.93(b). The project provides transitional housing paired with intensive case management, a required on-site self-sufficiency course, and connections to employment and mainstream benefits to help families increase income and move to permanent housing.

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)

Dawson Beach Transitional Housing provides supportive services focused on increasing family income so households can pay rent and sustain permanent housing after exit.

Dedicated case management: A Dawson Beach Transitional Housing Case Manager works with every adult household member and provides housing counseling. Families meet with the case manager weekly when they enter the program, moving to monthly meetings as they reach goals and their needs change, and more often whenever needed. The case manager tracks each family's progress, including which recommended resources were used, and measurable improvements in income, credit, savings, and crisis management.

Workforce development and job training: The case manager refers adults to workforce and job training organizations based on their goals, primarily Prince William Career Works, the local American Job Center, for job search assistance, career services, and training; and Virginia Cooperative Extension for financial education and life skills. Each adult develops a career action plan with specific steps toward employment or career advancement, which the case manager tracks over time.

Required self-sufficiency course: All adults complete CHOICES, a required 17-week structured self-sufficiency course provided on site by a third-party partner. Holding the course on site removes transportation and scheduling barriers. CHOICES covers topics including budgeting, credit improvement, and building the skills needed to increase and manage income.

Financial capability: Families create and track monthly budgets with their case manager. The program requires each household to put 5% of its income each month toward savings or debt repayment, building savings for move-in costs and reducing debt that can prevent families from qualifying for rental housing. The case manager also provides guidance on improving credit, a common barrier to leasing.

Income tracking: Dawson Beach calculates household income at program entry and exit to measure progress and adjust services. Together, these services give families the income, financial skills, and credit standing they need to pay rent and remain stably housed.

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)

Dawson Beach Transitional Housing leverages mainstream family service systems to stabilize household income and reduce the cost of housing and daily needs for the families it serves.

Screening and referral: The Dawson Beach case manager screens every family for public benefits at intake and continues screening throughout participation as circumstances change. Eligible families are referred to the Prince William County Department of Social Services (DSS), which administers most mainstream family benefits, and the case manager helps families complete applications and follow through.

Mainstream benefits accessed: Families are connected to the full range of mainstream supports for which they qualify, including Temporary Assistance for Needy Families (TANF); the Virginia Initiative for Education and Work (VIEW), Virginia's TANF employment program; Supplemental Nutrition Assistance Program (SNAP); Women, Infants, and Children (WIC); Medicaid and FAMIS health coverage for parents and children; childcare subsidy; energy assistance; child support enforcement; and Head Start.

Integrating TANF with employment: TANF provides families with cash assistance while VIEW connects parents to employment services, job training, and work activities, reinforcing the project's focus on increasing earned income. TANF income is counted toward the program's minimum monthly income requirement, allowing families to qualify for and remain in the program while they work toward employment.

Building benefits into financial plans: Public benefits are built into each family's monthly budget and savings plan. By using SNAP, WIC, energy assistance, and childcare subsidy to cover basic needs, families can direct more of their income toward rent, savings, and debt repayment, including the program's required 5% monthly savings or debt payment. Child support enforcement helps secure an additional, ongoing source of income.

Results: 5 families received mainstream benefits during their participation in the past year. By combining these mainstream resources with CoC housing and case management, Dawson Beach maximizes the funding available to each family and helps families build a stable financial foundation for permanent housing.

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)

Dawson Beach Transitional Housing combines housing assistance with services that support parents and children, coordinated through the project's dedicated case manager.

Childcare: The case manager connects families to childcare subsidies through the Prince William County Department of Social Services and to Head Start, so parents can work, attend job training, and complete the program's required CHOICES self-sufficiency course. Childcare costs are built into each family's monthly budget.

Parenting support: [Describe parenting support, e.g., parenting topics covered in CHOICES, parenting classes through Virginia Cooperative Extension or another partner, or case management focused on parenting goals.]

Pregnancy-related and child healthcare: The case manager connects pregnant and parenting family members to WIC for prenatal and early childhood nutrition and health screening, and to Medicaid and FAMIS so parents and children have health coverage for prenatal care, well-child visits, immunizations, and other medical needs. The case manager screens for these benefits at intake and throughout participation. [Add any direct links to health providers, e.g., Greater Prince William Community Health Center or the Prince William Health District.]

Education: Head Start provides early childhood education for young children. [Describe school-age support, e.g., coordinating with Prince William County Public Schools McKinney-Vento liaisons to keep children enrolled in their school of origin, arranging transportation, and ensuring access to school supplies and meals.] For parents, the required 17-week CHOICES course, held on site, provides education in budgeting, credit, and self-sufficiency, and the case manager refers parents to Prince William Career Works for job training and education.

Integration with housing: Each family's services are built into a single plan with the case manager, who meets with families weekly at program entry and monthly as they progress. This integrated approach keeps children stable and in school while parents build the income and skills needed to move to permanent housing.

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 DC VA Medical Center, Virginia Department of Veterans Services, the PWC Veterans Treatment Docket, and three SSVF providers: Volunteers of America Chesapeake & Carolinas, Friendship Place, and Operation Renewed Hope Foundation. At bi-monthly Veteran By-Name List meetings, these partners and CoC outreach and shelter providers review each Veteran experiencing homelessness, coordinate services and housing, and address service gaps.

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 ACTS (Action in Community Through Service), a victim service provider that operates a DV hotline linked to Coordinated Entry, emergency shelter, and DV Rapid Rehousing, and provides counseling and legal advocacy to survivors of domestic violence, dating violence, sexual assault, and stalking. ACTS meets monthly with the Office of Community Safety, PWC Police, Victim Witness, and DSS in the DV Workgroup to coordinate safe referrals and housing.

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)

PWC DSS Homeless Services Division has an MOU with PWC Criminal Justice Services to prevent homelessness among people entering Intensive Community Supervision, providing shelter access, referrals, case staffing, and weekly communication. Coordinated Entry works with the jail re-entry program to plan housing or shelter before release, and the PWC Veterans Treatment Docket attends the Veteran By-Name List meetings to connect justice-involved Veterans to housing.

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)

Prince William County Department of Social Services, the CoC Lead Agency, contracts with the Supportive Shelter to serve adults experiencing homelessness whose medical or functional needs exceed what a standard shelter can support. Coordinated Entry uses a standardized Activities of Daily Living (ADL) assessment at shelter entry to identify needs in mobility, medication management, and self-care, and routes each person to a setting equipped to meet them, ensuring medically vulnerable residents r

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)

PWC DSS contracts with the Supportive Shelter to serve adults, including aging and elderly individuals, who are medically fragile or have disabling conditions that a standard shelter cannot accommodate. An on-site nurse provides health monitoring and medication support, and the Community Services Board (CSB) provides behavioral health services on site weekly.

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)

All CoC PSH projects require participants to meet the definition of chronic homelessness. Pathway Homes' PSH project serves chronically homeless adults with serious mental illness and co-occurring disabilities referred through Coordinated Entry. Participants pay 30% of adjusted income toward rent and receive individualized, recovery-oriented case management and supportive services that promote stability and independence.

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)

Pathway Homes' PSH project delivers behavioral healthcare directly in participants' homes, bringing services to where participants live rather than requiring them to travel to a clinic. Pathway Homes is a behavioral health organization that has served adults with serious mental illness (SMI) and co-occurring disorders since 1980, and every participant in its PSH project has an SMI and a history of chronic homelessness.

Pathway Homes case managers and counselors conduct regular home visits [frequency, e.g., weekly] to provide on-site behavioral health support. Services begin with an assessment of each participant's needs, strengths, and goals, which the participant and case manager use to develop a person-centered recovery plan together. The plan is updated at regular intervals and whenever a participant's circumstances change significantly.

On-site services include symptom management, medication monitoring, crisis intervention, safety assessment, substance use relapse prevention, and counseling. Staff also provide skill building focused on daily living, managing mental and physical health, maintaining a home, and strengthening personal relationships, which directly supports housing stability. Health and wellness support extends to physical health monitoring and medical case management, recognizing that many participants have co-occurring medical conditions.

Pathway Homes coordinates closely with Prince William County Community Services, the area's Community Services Board (CSB), which refers participants into PSH through Coordinated Entry. For participants who need services beyond what Pathway provides in the home, staff connect them to CSB outpatient treatment, psychiatric and medication management services, the Program for Assertive Community Treatment (PACT), Medication Assisted Treatment (MAT), peer support, and crisis services. Pathway Homes staff participate in treatment planning with these providers so that in-home support and clinical treatment reinforce each other.

This model ensures participants receive consistent, on-site behavioral health support as a core part of their housing, rather than as a separate service they must seek out, which reduces crises, hospitalizations, and returns to homelessness.

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)

Pathway Homes' PSH project follows a written policy for assessing participant need for a higher level of care, established in the PWA CoC's PSH Move-On Strategy within the Coordinated Entry Policies and Procedures. The policy requires a comprehensive assessment of each participant's medical needs, financial readiness, and social supports to determine whether their current level of care remains appropriate, documented in the participant's file.

When assessments occur: Pathway Homes case managers complete a comprehensive assessment at intake covering behavioral health, physical health, functional abilities, and support needs. The resulting recovery plan is reassessed every 90 days and immediately when a trigger event occurs, including declining physical health, loss of ability to perform activities of daily living (ADLs), repeated psychiatric crises or hospitalizations, or escalating substance use. Regular home visits allow staff to identify these changes early.

How need is determined: When reassessment shows needs may exceed what PSH can safely provide, staff first determine whether added in-home supports, such as more frequent visits, home health aides, or intensive services through the Community Services Board's Program for Assertive Community Treatment (PACT), can meet the need in place. If not, CoC policy directs staff to help the participant obtain a local health department screening for long-term care and Medicaid waiver services using the Uniform Assessment Instrument (UAI), Virginia's standard eligibility tool for assisted living and nursing facility care. Staff review results with the participant, their providers, and PWC Community Services to select the appropriate setting.

Connecting to higher levels of care: Pathway Homes operates two Assisted Living Facilities (ALFs) licensed by the Virginia Department of Social Services, including an eight-bedroom ALF in Prince William County that provides 24/7 case management, counseling, nursing, and ADL support for adults with serious mental illness. Participants needing residential substance use treatment, detox, or inpatient psychiatric care are referred through the CSB and community treatment partners.

Staff plan each transition with the participant to maintain continuity of care, ensuring every participant receives the level of care their needs require while PSH units remain available for others experiencing chronic homelessness.

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

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

(limit 2,500 characters)

The CoC's PSH Move-On Strategy, included in the Coordinated Entry Policies and Procedures, governs how Pathway Homes' PSH project assesses participant readiness to move on to unsubsidized or other permanent housing. The strategy supports participants with disabilities who have achieved stability in PSH and are ready for more independent living, transitioning them to appropriate housing with continued access to needed supports while creating PSH openings for people experiencing chronic homelessness with greater needs.

Assessment and Readiness: Pathway Homes case managers conduct a comprehensive assessment of each participant's ability to live independently with less or no structured case management, evaluating medical needs, financial readiness, and social support. Case managers develop individualized move-on readiness criteria covering financial sustainability, mental health stability, and support systems, including home health aides or other in-home supports. Participants are engaged in discussions about their long-term housing goals so each transition is person-centered. Completed assessments are kept in the participant's file.

Housing Navigation: When a participant is assessed as ready, staff identify affordable housing options, including subsidized apartments, housing vouchers, and Medicaid waiver programs. Staff help participants apply for housing subsidies and support programs, including waitlisted programs during open enrollment periods, and provide technical assistance with applications.

Skills and Resources: To build and sustain independence, Pathway Homes provides independent living skills training in budgeting, medication management, and self-advocacy; connects participants to employment and vocational rehabilitation programs; and ensures continued access to SSI/SSDI, Medicaid, Medicare, and health services.

Transition and Post-Move Stability: Staff develop a transition plan identifying all support services needed to sustain housing, offer moving resources such as deposit assistance and furniture referrals, and provide up to 30 days of post-move services to monitor the transition and address problems early.

Through this strategy, participants move on only when assessment shows they are ready, with a clear plan and supports in place, which protects their housing stability and increases PSH availability for others.

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

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

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

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

You must upload the Local Competition Scoring Tool attachment to the 4A. Attachments Screen.
Select 'Yes' or 'No' in the chart below to indicate how your CoC reviewed, rated, and ranked project applications during your local competition:

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

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

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

	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website–which included: 1. the CoC Application, and 2. Project Priority Listings.	09/29/2026

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

	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/29/2026

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

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

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

1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	08/04/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

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

	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	08/04/2026

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

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

(limit 2,500 characters)

1. The PWA CoC's reallocation process is defined in its CoC Funding Policies & Procedures for HUD Grant Funded Projects (updated 5/14/2026). The Program Analysis and Ranking (PAR) Committee leads the process. Each year the Collaborative Applicant scores every renewal project on a PAR-approved evaluation tool using HMIS APR data, spending, match, and system performance measures. The CoC also reviews performance quarterly through the CoC Report Card. Lowest-scoring projects are prioritized for monitoring, and all projects are monitored at least every four years; findings require a Corrective Action Plan within 30 days. A project becomes a reallocation candidate if it: scores below 50% of available points and/or ranks in the bottom two, for two or more years or after a chance to improve; spends 95% or less of its grant for two or more years; has serious or repeated compliance problems with CoC Written Standards, Coordinated Entry, or unresolved HUD findings; fails to resolve a Corrective Action Plan; is less needed in the community; or voluntarily relinquishes funds. The PAR Committee uses a needs and gaps analysis of PIT, HIC, and HMIS data to direct reallocated funds to new, higher-priority projects, and requires a transition plan so participants in affected projects keep access to services. Decisions are approved by the Governance Committee and CoC membership.

2. Yes. Through its FY 2026 renewal evaluation, the PAR Committee identified one low-performing project: Pathway Homes' PSH project (VA0132), which ranked in the bottom two renewal projects. The PAR Committee also reviewed and accepted Good Shepherd Housing Foundation's decision to voluntarily relinquish funding for its PSH project (VA0130) rather than renew; as a non-renewing project, it was not scored.

3.Yes. Based on its evaluation, the PAR Committee recommended that Pathway Homes not renew VA0132 as PSH and instead reallocate its funds to apply as a new Transitional Housing project through a transition grant, better matching the project to participant needs and HUD priorities. The CoC also reallocated $217,641 from VA0130 to create new Transitional Housing and Supportive Services Only projects.

4.The CoC did reallocate this year. The only project identified as low performing was reallocated through a transition grant, and the relinquished funds were reallocated to new projects, so no identified project renewed in its current form.

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

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

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

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

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

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

	Enter the name of the HMIS Vendor your CoC is currently using.(limit 75 characters)	Wellsky

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

	Select from dropdown menu your CoC's HMIS coverage area.	Single CoC

2A-3.	PIT Count–Methodology Change.	

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

(limit 2,500 characters)

1. The PWA CoC maintained the same core unsheltered PIT Count methodology in 2026 as in 2025, a complete street-based census consistent with HUD PIT Count guidance, which allows for reliable year-over-year comparison. The CoC made one data quality change to strengthen implementation: it deployed smaller teams, fielding 10 teams with more than 50 volunteers. Smaller teams allowed the CoC to divide the geographic area into more focused assignments, cover known sleeping locations more thoroughly and efficiently, and spend more time engaging each person encountered, improving the completeness and accuracy of survey data. The CoC also continued and strengthened other data quality practices: updated volunteer training on the survey tool and on completing observation surveys for people who decline or cannot be approached; pre-canvassing of known sleeping locations to verify sites and inform residents about the count; partnerships with PWC Park Rangers and the Sheriff's Office to safely reach areas staff cannot otherwise access; bilingual volunteers to engage Spanish-speaking residents; and incentives such as gift cards and hot meals to encourage participation.

2. The 2026 unsheltered count decreased by 30%, from 115 persons in 2025 to 81 in 2026, a reduction of 34 persons. Because the smaller-team approach expanded rather than reduced coverage, the CoC is confident the decrease does not reflect undercounting. The data point instead to expanded hypothermia shelter capacity: 34 additional beds were available on the night of the count, and the sheltered count rose 11%, or 27 persons, over the same period. This shift from unsheltered to sheltered homelessness shows that the targeted expansion of shelter capacity had an immediate, measurable impact, moving people off the street and into settings where they can be connected to Coordinated Entry, case management, and housing. The CoC views the unsheltered decrease as the result of this intervention, not a change in methodology, and will continue using the same approach to maintain consistent year-over-year data.

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)

During the evaluation period of July 1, 2024 through June 30, 2025, the PWA CoC reduced the number of encampments in its geographic area by 66.7%, closing six of nine identified encampments and exceeding its goal of a 20% reduction. The CoC achieved this through four coordinated actions.

Dedicated street outreach: Prince William County Government, through the Department of Social Services, the CoC Lead Agency, invested in three staff members dedicated to street outreach. This team identifies people living in encampments, builds trust through repeated engagement, completes Coordinated Entry assessments, and connects individuals to shelter, housing, and services. Because the team is dedicated to unsheltered homelessness, it established the CoC's first baseline of nine encampments, giving the CoC a clear starting point for measuring progress.

Behavioral health integration: Outreach staff partner with the Community Services Board's PATH Program to connect encampment residents to mental health and substance use treatment based on their identified needs. Addressing these needs directly removes a major barrier to accepting shelter and housing.

Monthly outreach coordination: The CoC holds a dedicated monthly meeting with outreach providers to share information, coordinate services, identify gaps, and develop strategies for people who do not engage with traditional services. This meeting includes law enforcement and other public safety partners, confirm. Coordinated case planning prevents duplication and ensures each encampment has a clear engagement plan.

Measurable goals through the Panhandling Initiative: In conjunction with the County's Panhandling Initiative, County effort to connect people panhandling to services, the CoC set a target to reduce encampments by 20%, creating accountability for outreach, behavioral health referrals, and other interventions.

Outcomes: During the evaluation period, street outreach served 407 people. Of 341 exits, 115 (34%) were to positive destinations, including 77 to emergency shelter and 32 to permanent housing. Once sites were vacated, the County / property owners cleared or secured them to prevent re-establishment. The CoC will continue tracking encampments monthly to sustain these reductions.

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

1. Enter the estimated number of encampments in the beginning of your evaluation period.	9
2. Enter the reduction in the number of encampments during your evaluation period.	6

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

1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	59
2. Enter the reduction in the number of people in encampments during your evaluation period.	7

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

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

(limit 2,500 characters)

Not Applicable. The PWA CoC reduced the number of encampments by 66.7%, from 9 to 3, during the evaluation period of July 1, 2024 through June 30, 2025, as reported in 2A-4a. The CoC will continue its dedicated street outreach, PATH partnership, and monthly outreach coordination to sustain and build on this reduction.

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)

Per FY 2025 System Performance Measure 5.2, 529 persons became homeless for the first time, a 2% increase from 518 in FY 2024 but 6% below the FY 2023 level of 561. To reverse this uptick, the CoC's plan targets people at the point of crisis, before they enter the homeless system.

Identifying risk: Coordinated Entry (CES) screens every household seeking shelter for prevention and diversion eligibility. The CoC uses HMIS and CES data to identify the most common drivers of first-time homelessness, [e.g., eviction, doubled-up situations ending, loss of income, and discharge from institutions], and targets resources to those factors.

Diversion: CES staff use problem-solving conversations to help households identify safe alternatives to shelter, such as returning to family or friends with mediation or one-time financial help. The CoC trains CES and shelter staff in diversion annually, and CoC policy requires shelters to continue diversion efforts after entry.

Eviction prevention: Households facing eviction receive case management, landlord mediation, legal assistance, employment support, and mainstream benefits enrollment, along with rental assistance to keep them housed. The CoC dedicates $188,675 in Virginia Homeless Solutions Program prevention funds and $450,000 in local funds to prevention and one-time rental assistance.

Housing retention: The CoC's [3.5] FTE Housing Locators provide tenancy education and housing retention support, and maintain landlord relationships that help resolve problems before they lead to eviction.

New actions for FY 2026-2027: The CoC will (1) partner with the General District Court to connect tenants facing eviction to prevention funds and mediation before judgment; (2) establish a discharge referral pathway with Sentara Northern Virginia Medical Center and the jail re-entry program so at-risk individuals are screened for housing risk before release; and (3) add diversion and prevention outcome measures to the CoC Report Card to target funding to the most effective strategies.

Measurable goal and oversight: The CoC's goal is to reduce first-time homelessness by 10% from the FY 2025 baseline of 529, to 476 or fewer, by September 2027. The Service Continuum Committee reviews prevention and diversion data quarterly, including diversion success rates and the percentage of prevention clients who remain housed, and adjusts strategies and funding based on results.

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)

Per FY 2025 System Performance Measure 1.2, the average length of time persons remained homeless in the PWA CoC was 127 days, down from 130 in FY 2024 and 131 in FY 2023, a steady three-year decrease. According to HUD's SPM dashboard, the CoC's 2020-2024 average of 130 days has remained well below the national average of 165 days. The CoC's plan builds on this progress.

Prioritizing the longest stayers: Coordinated Entry (CES) prioritizes households with the longest time homeless for PSH and RRH referrals. Partners review the By-Name List (BNL) at regular case conferencing meetings to match each household to the fastest available housing pathway and resolve barriers to move-in.

Strengthening BNL data: Through its 2026 Built for Zero realignment, the CoC is implementing a monthly data quality process for CES data and updating system-wide prioritization policies. Accurate, real-time BNL data allows the CoC to identify households whose stays are growing longer and intervene sooner.

Reducing time to move-in: The CoC's Housing Locators recruit and maintain relationships with landlords who have available units, so households matched to housing can move in quickly. Housing Locators also help households gather documents, such as identification and income verification, while they wait for a match, so no time is lost once a unit is available.

Expanding housing capacity: The CoC uses its annual needs and gaps analysis to direct new and reallocated funding to the housing types most needed. In the FY 2026 competition, the CoC reallocated funds to create new projects [name types], adding capacity to move households out of homelessness faster.

Moving on from PSH: The CoC's PSH Move-On Strategy helps stable PSH participants transition to other permanent housing, freeing PSH units for people with the longest histories of homelessness.

Measurable goal and oversight: The CoC's goal is to maintain under the national average and reduce the average length of time homeless to under 127 days by September 2027. The Service Continuum Committee reviews length of time homeless data quarterly as a standing Built for Zero agenda item and adjusts strategies based on results.

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?	47.00%

Describe how you calculated the data for this response.

(limit 2,500 characters)

The PWA CoC calculated this measure using HMIS data for the reporting period of October 1, 2024 through September 30, 2025.

Universe of projects: The CoC created an HMIS reporting group containing all Transitional Housing (TH), Rapid Re-Housing (RRH), and Permanent Supportive Housing (PSH) projects operating in the CoC during the reporting period. No other project types were included.

Data source: The CoC ran the CoC Annual Performance Report (APR) for the combined TH/RRH/PSH reporting group and used Question 23c (Exit Destination) to identify each participant's exit destination, as recorded in HMIS Data Element 3.12.

Numerator: The CoC summed all participants who exited to the four unsubsidized destinations specified by HUD: "Staying or living with family, permanent tenure"; "Staying or living with friends, permanent tenure"; "Rental by client, no ongoing housing subsidy"; and "Owned by client, no ongoing housing subsidy." This totaled [59] exits, all to rental by client with no ongoing housing subsidy.

Denominator: The combined projects had 129 total exits during the reporting period. 4 exits were excluded because their destinations fall outside the applicable exit population in APR Question 23c, resulting in 125 applicable exits.

Calculation: The CoC divided 59 exits to unsubsidized housing by 125 applicable exits, resulting in 47% of participants exiting TH, RRH, and PSH collectively to unsubsidized housing, well above HUD's 20% benchmark.

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

	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	02/04/2026

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

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

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

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

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

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

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

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

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	214	18	212	91.38%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	54	0	54	100.00%
4. Rapid Re-Housing (RRH) beds	79	30	92	84.40%
5. Permanent Supportive Housing (PSH) beds	194	0	44	22.68%
6. Other Permanent Housing (OPH) beds	48	0	6	12.50%

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

	For each project type with a bed coverage rate that is 84.99 percent or lower in question 2A-9, describe:
1.	steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type, and
2.	how your CoC will implement the steps described to increase bed coverage to at least 85 percent.

(limit 2,500 characters)

The PWA CoC will address each project type with a bed coverage rate of 84.99% or lower through the following steps over the next 12 months:

Rapid Re-Housing (84.40%): The 21 RRH beds not represented in the PWA HMIS are VA Supportive Services for Veteran Families (SSVF) beds. SSVF providers serving Prince William currently enter data in either the District of Columbia or Fairfax CoC HMIS. Because SSVF providers serve veterans across multiple jurisdictions, addressing this gap requires regional coordination. The CoC will continue regional efforts to address this data gap, including data-sharing discussions and coordination with SSVF providers and regional partners to identify a sustainable approach for representing these beds.

Permanent Supportive Housing (22.68%): The PSH coverage rate reflects 75 HUD-VASH vouchers representing 150 beds that are included in the HIC but are not represented in the PWA HMIS. Addressing the HUD-VASH data gap requires solutions beyond what a single CoC can accomplish because VHA/VAMC systems serve veterans across multiple jurisdictions. The CoC participates in the monthly #OneTeam4Vets All Hands on Deck call series hosted by the VHA Homeless Programs Office and recently participated in the kickoff for a quarterly call with the DC VAMC. The CoC will use these forums to communicate how the absence of HUD-VASH data in HMIS affects CoC performance and NOFO reporting and to identify the technical, policy, and coordination steps needed for a regional data-sharing solution. The CoC will also engage CoCs that have successfully implemented HUD-VASH data imports. The CoC will implement a sustainable regional approach if one becomes available.

Other Permanent Housing (12.50%): This is the first time since at least 2019 that the CoC’s OPH coverage has fallen below 100%. The coverage rate reflects 30 HOME-ARP/TBRA certificates representing 42 beds in a short-term, 1–2-year program. The certificates were required to be included in the HIC but were not required to participate in HMIS, and the provider elected not to conduct HMIS data entry due to the program’s short-term nature. Because the program is expected to continue into FY2027, the CoC will work with the provider to determine whether HMIS participation is feasible, document the circumstance through HIC/HMIS reconciliation, and monitor the program’s status and future OPH inventory.

3A. Policy Initiatives

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

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

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

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

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

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

4A. Attachments Screen For All Application Questions

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

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

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

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

Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	1C-1. List of TH/...	09/28/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	List of CoC Progr...	09/28/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	1C-3. Language fr...	09/28/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	1C-10. Evidence o...	09/28/2026
05. 1D-1. Local Competition Scoring Tool	Yes	1D-1. Local Compe...	09/28/2026

06. 1D-2c. Local Competition Selection Results	Yes	1D-2c. Local Comp...	09/28/2026
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		
11. Other	No		

Attachment Details

Document Description: 1C-1. 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: 1C-3. Language from Project Supportive Service Agreements

Attachment Details

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

Attachment Details

Document Description: 1D-1. Local Competition Scoring Tool

Attachment Details

Document Description: 1D-2c. 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:

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/24/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/28/2026
1C. Coordination and Engagement	09/28/2026
1D. Project Review/Ranking	09/28/2026
2A. HMIS Implementation	09/28/2026
3A. Policy Initiatives	09/28/2026
4A. Attachments Screen	09/28/2026
Submission Summary	No Input Required

FY 2026

VA-604 – Prince William Area Continuum of Care

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

Documents include the following:

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

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

Number of TH, RRH, PSH Projects:	**6**
Number of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	**2**
Percent of TH, RRH, PSH Projects with On-site Substance Use Treatment Available:	**33%**

Applicant Name	Project Name	Project Type	On-site Substance Use Treatment Available?
Action in Community Through Service of Prince William	VA0324 ACTS RRH	PH-RRH	No
Action in Community Through Service of Prince William	VA0439 ACTS DV Bonus	PH-RRH	No
Streetlight Community Outreach Ministries	VA0127 PWA PASS PSH	PH-PSH	No
Pathway Homes	VA0398 PWA PSH Bonus (Applied as Transition Grant TH)	TH	Yes
KALMA	DV Transitional Housing (New Applicant)	TH	No
SLS Home Solutions	Transitional Housing (New Applicant)	TH	Yes

FY 2026

VA-604 – Prince William Area

Continuum of Care

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

Documents include the following:

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

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

Persons reporting chronic substance use in the CoC's 2026 PIT count:	**48**
Number of Units w/Required Substance Use Treatment:	**25**
Ratio of Units w/Required Substance Use Treatment to Persons w/chronic substance use:	**1 : 1.9**

Applicant Name	Project Name	Project Type	Substance Use Treatment Required: # Units
Action in Community Through Service of Prince William	VA0324 ACTS RRH	PH-RRH	0
Action in Community Through Service of Prince William	VA0439 ACTS DV Bonus	PH-RRH	0
Streetlight Community Outreach Ministries	VA0127 PWA PASS PSH	PH-PSH	0
Pathway Homes	VA0398 PWA PSH Bonus (Applied as Transition Grant TH)	TH	15
KALMA	DV Transitional Housing (New Applicant)	TH	0
SLS Home Solutions	Transitional Housing (New Applicant)	TH	10

FY 2026

VA-604 – Prince William Area Continuum of Care

1C-3. Language from Project Supportive Service Agreements

Documents include the following:

- **ACTS RRH Program Participation Agreement**
- **ACTS DV RRH Program Participation Agreement**
- **Pathway Homes Supportive Services Agreement**
- **SCOM Participant Agreement**
- **SLS Supportive Services Agreement**
- **KALMA Supportive Services Agreement**

ACTS RRH Program Participation Agreement

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

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

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

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

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

☐ Housing Search & Placement, Landlord Recruitment & Engagement, Rental Assistance, Move-In, Financial Assistance, Case Management, Income & Employment Support, Mainstream Benefits Support, Budgeting & Financial Stability, Transportation & Community Resources, Referrals & Warm Handoffs, Housing Retention and Ongoing Housing Stability Planning.

As a participant in gree to:

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

☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.

☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.

☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.

☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

Participant Signature Date

Program Staff Signature Date

ACTS DV RRH Program Participation Agreement

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

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

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

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

HUD DV Bonus provides the following supportive services to help participants obtain and retain permanent housing:

☐ Rapid Rehousing, Case Management, Housing Location/Landlord Engagement, Safety Planning, Financial Assistance, Employment and Income Support, Behavioral & Wellness Health Referral, Transportation Assistance and Housing Stability follow-up.

As a participant in HUD DV Bonus, I agree to:

☐ Meet or communicate with my assigned case manager at least

☐ Participate in regular case management or service planning focused on maintaining housing, increasing independence, and connecting to needed supports.

☐ Work with program staff to create, review, and update my Individualized Service Plan and Housing Stability Plan.

☐ Work with my case manager to pursue employment and/or benefits that will help support my housing stability and self-sufficiency.

☐ Tell program staff about major changes that may affect my housing, income, household, health, safety, or ability to participate in services.

☐ Let program staff know if I cannot attend a scheduled meeting and work with staff to reschedule.

.

Participant Signature Date

Program Staff Signature Date

Pathway Homes Supportive Services Agreement

This Agreement provides a standard program service agreement framework tailored to meet HUD Continuum of Care (CoC) mandatory service participation requirements.

Program Service Agreement

Program Name:
Agency Name:
Participant Name:
Unit Address:

---

1. Purpose of Agreement

This Program Service Agreement ("Agreement") outlines the supportive service participation required for housing assistance through the [Insert Program Name]. To maintain enrollment and maximize housing stability, the Participant agrees to actively engage in, at minimum, the individualized supportive services outlined below.

2. Mandatory Service Participation Requirements

In accordance with HUD FY 2026 CoC program guidelines, project funding and maximum application scoring require mandatory participant engagement in supportive services. The Participant therefore agrees to adhere to the following service milestones:

- **Case Management:** Meet with an assigned Case Manager at least once per calendar month for a housing stability review.
- **Service Plan Development:** Cooperate in creating an Individualized Service Plan (ISP) at least annually, and updating the ISP at least every 90 days.
- **Goal Engagement:** Actively work toward mutually agreed-upon goals, which may include employment assistance, benefits enrollment, or life skills training.
- **Specialized Care (If Applicable):** Attend scheduled outpatient addiction treatment, mental health counseling, or substance use disorder programs as determined by the ISP.

3. Agency Responsibilities

Pathway Homes agrees to support the Participant by providing:

- Regular, accessible case management meetings at the participant's home or other mutually agreed upon location.
- Direct referrals to healthcare, job training, education, and, benefits, and legal resources.
- Ongoing advocacy with landlords to ensure long-term housing retention.

4. Non-Compliance and Review Process

Supportive services are designed to prevent return to homelessness. If a Participant fails to meet the mandatory service milestones outlined in the Agreement:

1. **Verbal Warning:** The Case Manager will issue a verbal reminder and document the missed milestone.
2. **Written Corrective Action Plan:** Continued non-compliance will result in a formal meeting to modify the ISP and address barriers to participation.

3. **Program Review:** Persistent refusal to engage in mandatory services may result in a formal review of project eligibility, up to and including termination from the housing program.

Note: Program termination will follow HUD-approved due process and will not automatically result in immediate lease eviction unless lease violations based on a separate Lease Agreement occur.

5. Acknowledgment and Signatures
By signing below, the Participant and Agency representative acknowledge they have read, understood, and agreed to the terms of this Program Service Agreement.

Participant Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

SCOM Participant Agreement

PERMANENT SUPPORTIVE HOUSING (PSH)

Program & Supportive Services Participation Agreement

Purpose This agreement explains StreetLight supportive services, participant responsibilities, and basic residential guidelines for the HUD Continuum of Care-funded PSH program.

Welcome to StreetLight

StreetLight Community Outreach Ministries provides HUD Continuum of Care (CoC)-funded Permanent Supportive Housing (PSH) to eligible individuals experiencing homelessness who have a qualifying disability and meet applicable program eligibility requirements.

Our goal is to help participants maintain safe, stable permanent housing while increasing health, independence, income, recovery, and long-term self-sufficiency.

1. Supportive Services & Case Management

StreetLight's PSH program incorporates supportive service participation requirements in accordance with 24 CFR 578.75(h). Requirements are individualized based on each participant's strengths, needs, preferences, and goals identified in the Individualized Supportive Plan (ISP) and housing-stability plan.

StreetLight provides or coordinates:

- Housing-focused case management
- Individualized service and housing-stability planning
- Health & Wellness services and healthcare navigation
- Behavioral health and substance use treatment referrals
- Mainstream benefits and SOAR coordination
- Employment, education, and vocational referrals
- Budgeting and financial-management support
- Independent-living and life-skills support
- Legal-service referrals
- Crisis intervention, safety planning, and care coordination
- Referrals to community resources and higher levels of care when needed

As a participant, I agree to:

- Generally maintain weekly contact with my assigned Case Manager, or follow another individualized schedule agreed upon with staff.
- Participate in applicable case management and service planning focused on maintaining housing and increasing independence.
- Work with staff to create, review, and update my ISP and housing-stability goals and make reasonable efforts to work toward agreed-upon goals.
- Work with my Case Manager to pursue appropriate employment, income, and/or benefit opportunities that support housing stability and self-sufficiency.

- Tell staff about significant changes affecting my housing, income, household, health, safety, or ability to participate.
- Let staff know when I cannot attend a scheduled meeting and work with staff to reschedule.

2. Important Limits on Required Services

StreetLight may require participation in appropriate non-disability-related supportive services consistent with applicable HUD requirements. StreetLight recognizes that federal requirements limit which disability-related services may be required as a condition of continued program participation.

StreetLight does not require disability-related treatment or services, such as mental health treatment, outpatient medical treatment, or medication services, when such participation may not be required under applicable federal requirements.

StreetLight's PSH program is not a substance use treatment program. Substance use treatment is not required as a condition of acceptance into or continued participation in StreetLight's PSH program.

Participants are strongly encouraged to use appropriate medical, behavioral health, substance use, recovery, and other services when those services may improve health, safety, recovery, or housing stability.

3. Health & Wellness

StreetLight provides additional Health & Wellness support through our Clinical Health & Wellness Case Manager, who works alongside Housing Case Managers to assist participants with complex medical and healthcare needs.

Services may include:

- Health education and healthcare navigation
- Medication education
- Coordination with physicians, hospitals, specialists, pharmacies, and other providers, with participant consent
- Assistance scheduling and following up with medical appointments
- Support with chronic health conditions
- Support following hospitalization or medical crisis
- Referrals to primary, specialty, dental, behavioral health, and substance use services
- Coordination of in-home care, skilled nursing, or other higher levels of care when appropriate

Participants retain the right to make their own medical and treatment decisions. StreetLight Health & Wellness staff do not replace physicians, emergency services, or licensed treatment providers. Call 911 in a medical emergency.

4. Behavioral Health, Substance Use & Recovery

StreetLight does not provide clinical behavioral health or substance use treatment as part of its PSH program. When a participant wants or needs additional support, staff provide hands-on assistance connecting the participant to appropriate community providers.

- Mental health services and crisis intervention
- Counseling and psychiatric services
- Detoxification and substance use treatment
- Recovery services
- Inpatient or residential treatment

Staff will continue supporting housing stability before, during, and following treatment whenever possible. A relapse, return to substance use, behavioral health condition, or decision not to participate in treatment does not automatically result in termination from the PSH program. Staff will work with the participant to address safety concerns, barriers, and housing stability.

5. Benefits, Income, Employment & Financial Stability

StreetLight helps participants access resources that can increase independence and housing stability, including:

- SSI/SSDI and SOAR assistance
- Medicaid and Medicare
- SNAP and other eligible public benefits
- Employment and vocational services
- Education and training
- Financial literacy and budgeting
- Credit and debt-management resources

Participants must report changes in income or household benefits to their Case Manager within 10 business days and participate in required annual or interim recertifications. Rent will be calculated according to applicable HUD requirements and the participant's lease or occupancy agreement.

Participants will work with their Case Manager to develop and periodically review a realistic household budget.

6. Residential Responsibilities

Participants are responsible for following their lease or occupancy agreement, applicable property/HOA requirements, and StreetLight residential guidelines.

Participants agree to:

- Use the unit as their primary residence.
- Keep the home and shared areas reasonably clean, sanitary, and safe.
- Respect neighbors, other participants, staff, and visitors.
- Avoid excessive noise, threats, violence, harassment, or behavior that endangers others.
- Properly use appliances, plumbing, heating, electrical systems, and other property.
- Report maintenance and safety problems promptly.
- Follow fire and emergency-safety requirements and applicable laws and property requirements.
- Not tamper with smoke detectors or other safety equipment.

Guests

Only approved household members may live in the residence. Participants must notify staff as required regarding visitors. Authorized guests must leave by 10:00 PM on weeknights and midnight on weekends and may not remain in the residence when the participant is not present.

Keys & Locks

Participants may not duplicate or give keys to another person or change locks without authorization. Keys must be returned when the participant leaves the residence.

Pets & Assistance Animals

Pets are not permitted unless otherwise authorized. Requests for service animals or assistance animals, including qualifying emotional support animals, will be addressed through StreetLight's reasonable-accommodation process and applicable fair housing requirements.

Drugs, Alcohol & Smoking

Illegal drugs may not be possessed, distributed, or used on StreetLight program property in violation of applicable law. Prescription medication may not be shared with others. Alcohol use or possession must comply with applicable law, the lease, and property/program requirements. Smoking is not permitted inside StreetLight housing units.

7. Reasonable Accommodations

If a disability makes it difficult for a participant to meet a program requirement, the participant may request a reasonable accommodation.

An accommodation may include changes in how or where meetings occur, assistance with communication, modification of a program procedure, or another reasonable adjustment that allows the participant equal opportunity to participate in the program. Staff will explain StreetLight's reasonable-accommodation process and assist participants in making a request.

8. When Participation Becomes Difficult

Failure to participate in required supportive services does not automatically result in program termination or loss of housing assistance. When participation becomes difficult, StreetLight staff use progressive engagement to understand barriers and identify solutions that promote continued housing stability.

- Additional outreach or check-ins
- Different meeting times, formats, or locations
- Changes to the individualized service or housing-stability plan
- Additional case-management support
- Referrals or care coordination
- Reasonable accommodations when applicable
- A written corrective or re-engagement plan when appropriate

If non-participation in a service that StreetLight is legally permitted to require continues after reasonable efforts have been made to help the participant re-engage, StreetLight may take further action under its written policies.

9. Program or Lease Violations

When concerns arise, StreetLight's first goal is to help the participant remain successfully housed. Whenever appropriate, staff will use supportive interventions, problem-solving, education, care coordination, reasonable accommodations, and corrective planning before considering termination.

Serious or repeated violations of the lease, occupancy agreement, safety requirements, or applicable program requirements may result in further action. Violence, serious threats to safety, illegal activity, or other serious circumstances may require immediate intervention.

Program termination is considered a last resort and will be handled in accordance with applicable HUD requirements, the participant's lease, program policies, and applicable law.

10. Notice and Review Before Termination

If StreetLight proposes termination of program assistance, the participant will receive the procedural protections required by applicable HUD regulations and StreetLight policy, including:

- **Written Notice** - A written explanation of the reason for the proposed termination.
- **Opportunity for Review** - An opportunity to present written or oral objections before a person other than the individual who made or approved the original termination decision.
- **Final Decision** - Prompt written notice of the final determination.

Termination of HUD program assistance and termination of a tenancy or lease are not necessarily the same action. Any applicable lease and landlord-tenant rights will also be followed.

11. Confidentiality & HMIS

StreetLight protects participant privacy and dignity. Information is collected and used for housing, case management, supportive services, program administration, HMIS, and required reporting.

Information will not be released outside the program without appropriate authorization except when disclosure is required or permitted by law. Only authorized staff may access participant information.

12. Grievances

Participants may raise concerns about services, staff, program decisions, or treatment without retaliation.

- Step 1: Speak with your Case Manager.
- Step 2: If unresolved, contact the Case Manager's Supervisor.
- Step 3: If still unresolved, contact the Executive Director.
- Step 4: If necessary, contact StreetLight's Board of Directors.

Staff will assist participants who need help understanding or using the grievance process.

Participant Acknowledgment

By signing below, I acknowledge that:

1. This agreement was reviewed with me.
2. I had an opportunity to ask questions.
3. I received or was offered a copy.
4. I understand that StreetLight's PSH program includes supportive-service participation requirements and that those requirements are individualized based on my needs, strengths, and goals.
5. I understand that I am generally expected to maintain weekly Case Manager contact and participate in applicable case management, service planning, housing-stability goals, and appropriate income, employment, or benefits activities.
6. I understand that StreetLight will use progressive engagement and work with me to address barriers if participation becomes difficult.
7. I understand that medical, behavioral health, medication, and substance use treatment are not automatically conditions of my continued participation in StreetLight's PSH program.
8. I understand that I may request a reasonable accommodation for a disability.
9. I understand my responsibilities under my lease, occupancy agreement, and applicable program requirements.
10. I understand that I have grievance and review rights.

Participant Name

Participant Signature **Date**

Program Staff Name

Program Staff Signature **Date**

SLS Supportive Services Agreement

SLS Home Solutions

Transitional Housing Supportive Services Agreement

Organization: SLS Home Solutions
Program: Faith-Based Transitional Housing Program

Purpose

The purpose of this agreement is to outline the supportive services available through the Transitional Housing Program and the responsibilities of both the participant and the organization. Our mission is to provide safe, stable housing and supportive services that promote self-sufficiency, housing stability, and successful transition to permanent housing.

Supportive Services

Participants will have access to services that may include:

- Individualized case management
- Housing stabilization planning
- Employment readiness and job placement assistance
- Resume development and interview preparation
- Budgeting and financial literacy
- Life skills training
- Referrals for healthcare, behavioral health, and substance use treatment
- Assistance applying for SSI, SSDI, SNAP, Medicaid, Medicare, TANF, and Veterans benefits, when eligible
- Transportation and community resource referrals
- Faith-based encouragement and voluntary spiritual support

Participation in faith-based activities is **voluntary** and is **not required** to receive housing or services.

Participant Responsibilities

Participants agree to:

- Meet with assigned staff or case managers on a regular basis to develop and review individualized housing stability goals.
- Actively participate in developing and working toward a permanent housing plan.
- Work toward increasing income through employment, education, vocational training, or eligible mainstream benefits, when appropriate.
- Maintain respectful behavior toward staff, volunteers, visitors, and fellow residents.
- Follow all house rules and safety requirements.

- Notify staff of changes in income, employment, household composition, or emergency contact information.
- Maintain the assigned living space in a clean and sanitary condition.
- Cooperate with referrals and housing navigation activities designed to support successful transition to permanent housing.
- Comply with all applicable program policies regarding safety and property maintenance.

Participation in supportive services is encouraged to promote successful housing outcomes. Services are individualized based on each participant's needs, strengths, and goals. The program will make reasonable accommodations for participants with disabilities. Housing assistance will not be terminated solely because a participant declines supportive services or experiences barriers to achieving program goals, except as permitted by applicable program requirements and safety policies.

Organization Responsibilities

The organization agrees to:

- Provide safe, decent, and supportive housing.
- Deliver or coordinate supportive services.
- Respect participant confidentiality and privacy.
- Treat all participants fairly and without discrimination.
- Provide reasonable accommodations for persons with disabilities.
- Assist participants in identifying resources that support long-term housing stability.

Acknowledgment

By signing below, both parties acknowledge that they have reviewed this agreement, understand its contents, and agree to work together toward achieving stable, permanent housing.

Participant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

KALMA Supportive Services Agreement

SUPPORTIVE SERVICES ENGAGEMENT AGREEMENT

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

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

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

- Housing Search, Placement, and Stabilization Support — Advocates help participants secure and move into a scattered-site transitional housing unit, and continue supporting them with lease compliance, landlord communication, and unit-related issues throughout their stay.

- Trauma-Informed Case Management and Advocacy — Each participant is paired with a dedicated advocate/case manager who provides individualized, trauma-informed support, answers questions, and helps them adjust to their new housing and circumstances.

- Safety Planning and Risk Assessment — Ongoing, collaborative safety planning that addresses the participant's specific risks as a domestic violence survivor, updated as circumstances change.

- Individualized Service Plan (ISP) and Housing Stability Plan Development — Participants work with their advocate to create, review, and regularly update a personalized plan identifying their goals, needed supports, and steps toward housing stability.

- Employment and Mainstream Benefits Assistance — Help pursuing employment and accessing mainstream benefits (such as SNAP, TANF, Medicaid, or childcare subsidies) to build financial safety, stability, and self-sufficiency.

- Life Skills Coaching — Practical support in areas like budgeting, tenant responsibilities, household management, and parenting, aimed at building independence.

- Referrals to Community-Based Services — Connections to outside resources including legal advocacy, medical and mental health care, substance use treatment and recovery supports, education, transportation, and childcare.

- Permanent Housing Transition Assistance — Support identifying and moving into permanent housing at program exit, so participants leave with a stable next step rather than a gap in coverage.

As a participant in KALMA Foundation, Inc, I understand the services offered and the encouragement to engage in them. Such services are:

☐ Meeting or communicating with my assigned advocate/case manager to answer questions and provide general support for adjusting to a new environment.

☐ Working with my advocate/case manager on safety planning, maintaining housing, increasing independence, and connecting to needed supports.

☐ Partnering with program staff to create, review, and update my Individualized Service Plan, Housing Stability Plan, and safety plan.

☐ Working with my advocate/case manager to pursue employment and/or benefits that will help support my financial safety and stability, ability to maintain my housing, and increase my self-sufficiency.

☐ Talking with program staff about support I need regarding sobriety and whether sobriety needs to be a part of ongoing safety planning.

☐ Telling program staff about major changes that may affect my housing, income, household, health, safety, or ability to engage with services offered.

☐ Letting program staff know if I cannot attend a scheduled meeting and working with staff to reschedule.

For Transitional Housing Projects

☐ I will be offered at least 20 hours per week of approved engagement activities, such as case management, treatment, counseling, employment, education, job training, volunteering, housing planning, etc.

☐ I will work with my advocate/case manager to create a schedule that works for me for regular check-ins. During these meetings, we will discuss safety planning and offer additional services.

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

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

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

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

Participant Signature Date

Program Staff Signature Date

FY 2026

VA-604 – Prince William Area

Continuum of Care

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

Documents include the following:

- DSS HSD Outreach SOP

Department of Social Services

Homeless Services Division

Outreach Program

Standard Operating Procedures

FY26 5.1.2026 - 6.30.2027

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Panhandling Initiative

The Panhandling Outreach Initiative is designed to support individuals who are panhandling by offering help, not punishment. Outreach staff will visit known panhandling locations to engage individuals with respect, compassion, and a non-judgmental approach. Staff will introduce themselves clearly, explain the purpose of the outreach, and begin conversations focused on understanding the person's needs, building trust, and offering resources such as shelter, food assistance, employment programs, and behavioral health services. Engagement is centered on listening, validating the person's experience, and providing realistic pathways toward stability.

Because many panhandling locations are near busy intersections, medians, and high-traffic areas, staff will always prioritize safety. Outreach workers will avoid stepping into traffic, remain on sidewalks or safe pull-off areas, and never encourage clients to approach vehicles or cross unsafe lanes. Conversations will be kept brief when necessary to avoid prolonged exposure to dangerous conditions, and staff will use clear, calm communication to guide clients to safer spots when possible. This initiative balances compassionate engagement with strong safety practices, ensuring both staff and clients remain protected while meaningful support is offered.

Encampment Closures

The following document is a brief overview of the steps to be taken when, a land or business owner has recently discovered there is person(s) who have created a homeless encampment on their property or single person is residing on their property. The landowner may be accruing fines (assessed by PWC) due to the debris on the property that needs to be cleaned up. In other cases, the owner may have a person or person on the property that wants to leave the property.

The Prince William County Police Captain assigned to the appropriate magisterial district will be contacted to initiate the encampment closure process. They will explain the closure procedures and follow up with the Homeless Services Outreach Team when "no trespassing" signs are posted every 50 feet along the length of the property. The owner is then given a point of contact at the PWC police department pending the district (East, Central or West).

This coordination ensures that law enforcement and outreach staff are aligned and aware of the conditions on site. The Human Services Manager will then coordinate with their team and other relevant departments to make their first contact with individuals at the encampment.

Next Steps After Confirmation of Signs Posted

	Tasks	Who Is Included
Week #1	1st visit engagement is to inform the residents the property needs to be vacated within 30 days and provide resources for a smooth transition.	PWC Police Dept., Community Services, Dept. of Social Services, Owner or Owner Representative
Week #2	No visit to the encampment.	N/A
Week #3	2nd visits continue engagement and remind client of the encampment closure. The outreach team will provide resources for a smooth transition.	PWC Police Dept., Community Services, Dept. of Social Services, Owner or Owner Representative
Week #4	Visit from the police department and any person still on the property after the date is arrested.	PWC Police Dept. Only

After the closure, Outreach Services continues to follow up with individuals who were displaced. The goal is to maintain continuity of care, support ongoing engagement, and continue offering pathways to shelter, housing, and services. Documentation is completed to record the services offered, client outcomes, and any challenges encountered during the closure process. This information helps improve future responses and ensures accountability.

Throughout the entire process, the guiding principles of Housing First, trauma-informed care, safety, transparency, and collaboration remain central. Encampment closures are not treated as isolated events but as part of a broader strategy to connect individuals experiencing homelessness with long-term, stable housing and supportive services.

FY 2026

VA-604 – Prince William Area

Continuum of Care

1D-1. Local Competition Scoring Tool

Documents include the following:

- **Renewal Projects Scoring Tool & Evaluation Criteria**
- **New Projects Scoring Tool & Evaluation Criteria**

Renewal Projects Scoring Tool & Evaluation Criteria

PWA CoC Renewal Project Scoring Tool
Appendix: Evaluation Standards Measure Types

Objective Measures: Performance measures that reflect CoC performance goals
Performance-Based Measures: Performance measures that reflect the HUD System Performance Measures (SPM)
Severity of Need Measures: Performance measures that reflect CoC prioritization goals

Evaluation Criteria	Data Source	Benchmark		Points	Measure Type
		PSH	RRH	ALL	
Performance (Base Points)					
Efficient Use of Resources					
Spending on last fully completed HUD grant year: % of grant funds expended	eLOCCS report	95%		10	Objective
Occupancy/Unit Utilization: Average utilization rate of project (using project utilization each quarter, as reported on APR)	1. HMIS APR (Q8b) 2. e-snaps report	95%		10	Objective
Eligibility					
Percentage of adult Heads of Household with previous residence that indicates the qualified category of homelessness for the project	1. HMIS APR (Q15) 2. Provider documentation	100%		10	Objective
PSH Only: Percent of Households w/at least one or more CH member	HMIS APR (Q26a)	95%	N/A	5	Objective
Rapid Return To Permanent Housing					
Average length of time to housing (time between project start date and housing move in date)	HMIS APR (Q22c)	Tenant-Based: <=30 days Site-Based: <=14 days		5	Objective & Performance
Participant Income/Resources					
Percentage of all adult participants who increased EARNED INCOME from entry to exit/follow-up (leavers and stayers)	HMIS APR (Q18, Q19a1, Q19a2)	15%	25%	10	Objective & Performance
Percentage of all adult participants who increased OTHER INCOME (NON- EARNED) from entry to annual assessment/exit (leavers and stayers)	HMIS APR (Q18, Q19a1, Q19a2)	70%	15%	5	Objective & Performance
Percentage of adult participants who maintained EARNED INCOME at annual assessment/exit (leavers and stayers)	HMIS APR (Q18)	15%	70%	5	Objective
Percentage of adult participants with 1 or more source of Non-Cash Benefit at annual assessment/exit (leavers and stayers)	HMIS APR (Q18, Q20b)	65%	55%	3	Objective
Length of Stay					

RRH Only: Percent of participants whose length of stay is 6 months or less	HMIS APR (Q22a1)	N/A	50%	5	Objective
Housing Stability					
PSH Only: Percentage of all participants who remain in PSH or exited to permanent housing*	HMIS APR (Q22a1, Q23c)	85%	N/A	5	Objective & Performance
RRH: Percentage of all leavers who exited to Permanent Housing*	HMIS APR (Q23c)	N/A	85%	5	Objective & Performance
Percentage of all leavers who exited to shelter, streets or unknown destinations	HMIS APR (Q23c)	Less than or equal to 5%		5	Objective
Returns: Percent of participants housed by the project that return to homelessness within 24 months of exiting to permanent housing	1. HMIS APR (Q23c) 2. HMIS SPM (Q2a, Q2b) 3. DSS Report	Less than 15%		10	Objective & Performance
Data Quality					
Timeliness of HMIS Data Entry - Entry Records created within 0 to 3 calendar days of project entry	HMIS APR (Q6e)	75%	75%	2	Objective
Compliance					
Match equals or exceeds statutory requirement	e-snaps report	25% excluding leasing		5	Objective
HUD Drawdowns Quarterly	eLOCCS report	Minimum quarterly draws		5	Objective
HUD Annual Performance Report (APR) Submission within 90 days of the end of the program year	Sage	Within 90 days of last fully completely grant cycle end		2	Objective
Supportive Services					
Supportive Services Requirements: Project requires participants to take part in supportive services (e.g., case management, employment training, substance use disorder treatment)	1. Supportive Services Agreement 2. Individualized Service Plan	Documentation Submitted		3	Objective
Total Performance (Base) Points				**PSH**	**100**
				RRH	**100**

HUD/CoC Priorities - Bonus Points

Evaluation Criteria	Data Source	Total Possible Bonus Points	Project Type	Measure Type
Severity of Need: % of adults with 2 or more disabilities at project start	HMIS APR (Q13a2)	2	ALL	Objective & Severity of Need
Severity of Need: % of adults that are domestic violence survivors	HMIS APR (Q14a)	2	ALL	Objective & Severity of Need
Severity of Need: % of adults entering project from a place not meant for human habitation	HMIS APR (Q15)	2	ALL	Objective & Severity of Need
Severity of Need: % of adults that are Transition Age Youth (18 - 24)	HMIS APR (Q11)	2	ALL	Objective & Severity of Need
Severity of Need: % of adults age 55+	HMIS APR (Q11)	2	ALL	Objective & Severity of Need
Total Bonus Points				**10**

TOTAL MAXIMUM POINTS (BASE + BONUS)	110

Measure Type Point Distribution			
All Project Types			
Measure Type	*Points Available*	*Percent of Points*	*HUD Standard per most recent NOFO*
Objective	100	100%	50%
Performance	40	40%	25%
Bonus Points (Severity of Need)	10	100%	CoC standard (not required by HUD)

PWA CoC Renewal Project Scoring Tool - Evaluation Standards						
The time period used to measure performance will be: 01/01/2025 - 12/31/2025 *Financial data will be measured based on the program year that ended during this report period* *Projects that were not operational for one full program year will not be competively scored*						
Evaluation Criteria	**Data Source**	**Benchmark**		**Points**	**Scoring Intervals**	
		PSH	**RRH**	**ALL**	**PSH**	**RRH**
Performance (Base Points)						
Efficient Use of Resources						
Spending on last fully completed HUD grant year: % of grant funds expended	eLOCCS report	95%		10	0.0% - 84.9% = score of 0; 85.0% - 94.9% = score of 5; 95.0% - 100.0% = score of 10	
Occupancy/Unit Utilization: Average utilization rate of project (using project utilization each quarter, as reported on APR)	1. HMIS APR (Q8b) 2. e-snaps report	95%		10	0.0% - 89.9% = score of 0; 90.0% - 94.9% = score of 5; 95.0% - 100.0% = score of 10	
Eligibility						
Percentage of adult Heads of Household with previous residence that indicates the qualified category of homelessness for the project	1. HMIS APR (Q15) 2. Provider documentation	100%		10	0.0% - 99.9% = score of 0; 100.0% = score of 10; HUD Standard: 100%	
PSH Only: Percent of Households w/at least one or more CH member	HMIS APR (Q26a)	95%	N/A	5	0.0% - 74.9% = score of 0; 75.0% - 84.9% = score of 1; 85.0% - 94.9% = score of 3; 95.0%- 100.0% = score of 5	
Rapid Return To Permanent Housing						
Average length of time to housing (time between project start date and housing move in date)	HMIS APR (Q22c)	Tenant-Based: <=30 days Site-Based: <=14 days		5	Tenant-Based: 181+ days = score of 0 61 - 180 days = score of 1; 31 - 60 days = score of 3; 0 - 30 days = score of 5; Site-based: 61+ days = score of 0 22 - 60 days = score of 1; 15 - 21 days = score of 3; 0 - 14 days = score of 5	
Participant Income/Resources						
Percentage of all adult participants who increased EARNED INCOME from entry to exit/follow-up (leavers and stayers)	HMIS APR (Q18, Q19a1, Q19a2)	15%	25%	10	0.0% - 4.9% = score of 0; 5.0% - 9.9% = score of 3; 10.0% - 14.9% = score of 6; 15.0% - 100.0% = score of 10	0.0% - 4.9% = score of 0; 5.0% - 9.9% = score of 3; 10.0% - 24.9% = score of 6; 25.0% - 100.0% = score of 10
Percentage of all adult participants who increased OTHER INCOME (NON- EARNED) from entry to annual assessment/exit (leavers and stayers)	HMIS APR (Q18, Q19a1, Q19a2)	70%	15%	5	0.0% - 39.9% = score of 0; 40.0% - 54.9% = score of 1; 55.0% - 69.9% = score of 3; 70.0% - 100.0% = score of 5	0.0% - 4.9% = score of 0; 5.0% - 9.9% = score of 1; 10.0% - 14.9% = score of 3; 15.0% - 100.0% = score of 5
Percentage of adult participants who maintained EARNED INCOME at annual assessment/exit (leavers and stayers)	HMIS APR (Q18)	15%	70%	5	0.0% - 4.9% = score of 0; 5.0% - 9.9% = score of 1; 10.0% - 14.9% = score of 3; 15.0% - 100.0% = score of 5	0.0% - 34.9% = score of 0; 35% - 49.9% = score of 1; 50.0% - 69.9% = score of 3; 70.0% - 100.0% = score of 5
Percentage of adult participants with 1 or more source of Non-Cash Benefit at annual assessment/exit (leavers and stayers)	HMIS APR (Q18, Q20b)	65%	55%	3	0.0% - 34.9% = score of 0; 35% - 49.9% = score of 1; 50.0% - 64.9% = score of 2; 65.0% - 100.0% = score of 3	0.0% - 24.9% = score of 0; 25% - 39.9% = score of 1; 40.0% - 54.9% = score of 2; 55.0% - 100.0% = score of 3
Length of Stay						
RRH Only: Percent of participants whose length of stay is 6 months or less	HMIS APR (Q22a1)	N/A	50%	5	N/A	0.0% - 24.9% = score of 0; 25.0% - 34.9% = score of 1; 35.0 % - 49.9% = score of 3; 50.0% - 100.0% = score of 5
Housing Stability						
PSH Only: Percentage of all participants who remain in PSH or exited to permanent housing*	HMIS APR (Q22a1, Q23c)	85%	N/A	5	0.0% - 44.9% = score of 0; 45.0% - 64.9% = score of 1; 65% - 84.9% = score of 3; 85.0% - 100.0% = score of 5	

RRH: Percentage of all leavers who exited to Permanent Housing*	HMIS APR (Q23c)	N/A	85%	5	0.0% - 44.9% = score of 0; 45.0% - 64.9% = score of 1; 65% - 84.9% = score of 3; 85.0% - 100.0% = score of 5
Percentage of all leavers who exited to shelter, streets or unknown destinations	HMIS APR (Q23c)	Less than or equal to 5%		5	0.0% - 5% = score of 5; >5.0% = score of 0
Returns: Percent of participants housed by the project that return to homelessness within 24 months of exiting to permanent housing	1. HMIS APR (Q23c) 2. HMIS SPM (Q2a, Q2b) 3. DSS Report	Less than 15%		10	0.0% - 14.99% = score of 10; 15.0% - 19.99% = score of 5; 20.0% - 24.99% = score of 3; >25% = score of 0
Data Quality					
Timeliness of HMIS Data Entry - Entry Records created within 0 to 3 calendar days of project entry	HMIS APR (Q6e)	75%	75%	2	0.0% - 49.9% = score of 0; 50.0% - 74.9% = score of 1; >75.0% = score of 2
Compliance					
Match equals or exceeds statutory requirement	1. e-snaps report 2. Sage	25% excluding leasing		5	0.0% - 24.9% = score of 0; 25.0% - 100.0% = score of 5 HUD Standard: 25% of expenditures requiring match
HUD Drawdowns Quarterly	eLOCCS report	Minimum quarterly draws		5	No = Score of 0; Yes = Score of 5; HUD Standard: Quarterly
HUD Annual Performance Report (APR) Submission within 90 days of the end of the program year	Sage	Within 90 days of last fully completely grant cycle end		2	Non-Timely Submission = Score of 0 Timely Submission (within 90 days of last fully completed grant cycle end) = Score of 2
Supportive Services					
Supportive Services Requirements: Project requires participants to take part in supportive services (e.g., case management, employment training, substance use disorder treatment)	1. Supportive Services Agreement 2. Individualized Service Plan	Documentation Submitted		3	Service Participation Not Required = Score of 0 Service Participation Required = Score of 3
Total Performance (Base) Points				**PSH**	**100**
				RRH	**100**

HUD/CoC Priorities - Bonus Points

Evaluation Criteria	Data Source	FY25 Total Possible Bonus Points	Project Type	FY25 Scoring Intervals
Severity of Need: % of adults with 2 or more disabilities at project start	HMIS APR (Q13a2)	2	ALL	Points are awarded propotionately by multiplying the total possible points by the percent of persons served during the report period that meet the condition
Severity of Need: % of adults that are domestic violence survivors	HMIS APR (Q14a)	2	ALL	
Severity of Need: % of adults entering project from a place not meant for human habitation	HMIS APR (Q15)	2	ALL	
Severity of Need: % of adults that are Transition Age Youth (18 - 24)	HMIS APR (Q11)	2	ALL	
Severity of Need: % of adults age 55+	HMIS APR (Q11)	2	ALL	
Total Maximum Bonus Points				**10**
TOTAL MAXIMUM POINTS (BASE + BONUS)				**110**

**Measure 11 and 12 exclude deceased participants as well as those exiting to foster care, hospitals/medical facilties and long-term care facilities/nursing homes*
Note: Domestic Violence projects will provide APR data from a comparable database.

New Projects Scoring Tool & Evaluation Criteria

FY26 PWA CoC New Project Application — Scoring Workbook

Companion scoring tool for the FY26 Prince William Area Continuum of Care New Project, Expansion & Transition Application.

How to use this workbook

Each tab below corresponds to one Project Component Type and mirrors the application's Section 7 (General Questions) and the matching Section 8 subsection exactly — same questions, same point values, same HUD threshold flags.

1. Open the tab matching the project type you are reviewing.
2. Fill in the reviewer name, organization name, and project name at the top of the tab.
3. For each question, enter the points you are awarding in the yellow Score column. Each cell is limited to that question's maximum points — entering more will show a validation warning.

4. Subtotals and the Grand Total update automatically as you enter scores.
5. Items marked THRESHOLD in red are HUD threshold criteria. For the two items that are attachment-based rather than point-scored (the TH and SSO-Standalone service agreement attachments), enter Y or N in the Score column to indicate whether the attachment was provided — these do not add to the point total.

6. Save the workbook (or “Save As” with the organization/project name) to keep your scoring record. Unlike the HTML version of this tool, this file saves normally like any other Excel file — no special server or internet connection is needed.

Total possible points by project type

Project Component Type	Tab	Max Points
Permanent Supportive Housing (PSH)	PSH	**104**
Rapid Re-Housing (RRH)	RRH	**102**
Transitional Housing (TH)	TH	**124**
Supportive Services Only — Standalone	SSO-Standalone	**98**
Supportive Services Only — Street Outreach	SSO-StreetOutreach	**98**
Supportive Services Only — Coordinated Entry	SSO-CoordEntry	**92**
HMIS Expansion	HMIS	**118**

This workbook runs entirely offline as a standard .xlsx file — nothing is uploaded, and no macros or internet access are required.

FY26 PWA CoC Scoring Tool — Permanent Supportive Housing (PSH)

Mirrors application Sections 7 (General Questions) and 8.1. Enter points awarded in column B.

Organization Name:	
Project Name:	
Reviewer Name:	

Question	Score	Max Pts	Notes
7.1 Experience			**0 / 18**
Every applicant completes this subsection.			
Describe your agency's experience with this program type, including current programs operated, number of participants, and scope. (Approx. 300 words)		3	
Provide examples of outcome data from similar programs, including employment income outcomes and prevention of returns to homelessness. (Approx. 200 words)		3	
Describe your organization's accreditations and licensures. (Approx. 150 words)		2	
Describe staff training requirements and ongoing development. (Approx. 200 words)		2	
Describe how people with lived experience are included in decision-making. (Approx. 150 words)		2	
Does your organization currently manage any federal funding? (Yes/No)		1	
Describe your agency's internal fiscal management systems. (Approx. 200 words)		2	
Audit history: independent audit in past 24 months, any findings/sanctions, and resolution steps if unresolved (combined across all 3 audit questions).		3	
7.2 Design of Housing & Supportive Services			**0 / 6**
Applies to all types except HMIS.			

Summarize the scope of the project: target population, housing/services overview, program design, anticipated persons/households served, coordination, use of CoC funds. (Approx. 300 words / 2,000 char limit)		2	
Describe why the scattered-site or project-based design was chosen and how it supports target population needs. (Approx. 200 words)		2	
Eligible Support Services table: provider and frequency for each applicable service.		2	

7.3 Mainstream Resources, Coordinated Entry & Cost Reasonableness — 0 / 30

Cross-cutting items that apply to this project type, asked once in the application's Section 7.3.

Explain how the project will be supplemented with resources from other public or private sources (mainstream health, social, employment programs)		15	*HUD Threshold. Limit 1,000 characters.*
Will your project participate in the CoC's Coordinated Entry (CES) System (or alternate process for victim service providers)? Describe how		6	*HUD Threshold. Limit 1,000 characters.*
Average Cost per Household Served — calculation completed (Total Annual Project Budget ÷ Number of Households Served Annually).		1	
Describe your plan for making substance use disorder treatment available on-site and/or easily accessible, including 24/7 access to detox/residential/inpatient care and unit participation-ratio fields.		6	
Prohibiting Illicit Drug Enablement: attestation and remedies narrative for housing/SSO projects.		2	*HUD Threshold. Limit 1,000 characters.*

7.4 Implementation — 0 / 9

Every applicant completes this subsection.

Describe pre-grant-start readiness activities and 60/120/180-day work plan and goals. (Approx. 300 words)		3	
Project milestone schedule (days from grant agreement execution), consistent with 12/24-month statutory deadlines.		2	

Specific metrics to track implementation/outcomes, including employment income gains and prevention of returns to homelessness. (Approx. 150 words)		2	
1–2 examples of program changes made as a result of outcome data in other programs. (Approx. 200 words)		2	

8.1 Permanent Supportive Housing (PSH)			**0 / 29**
PSH-specific questions.			
Demonstrate how the housing proposed, including number and configuration of units, will fit participant needs.		7	*HUD Threshold. Limit 1,000 characters.*
Demonstrate how supportive services and assistance will ensure participants obtain and retain permanent housing.		10	*HUD Threshold. Limit 1,000 characters.*
Describe how the project will be designed to serve homeless individuals/families with a disability (24 CFR 578.37(a)(1)(i)).		7	
Describe why the average cost per household served is reasonable and necessary (2 CFR 200.404).		5	*HUD Threshold. Limit 1,000 characters.*

7.6 Financials			**0 / 12**
Every applicant completes this subsection (including HMIS for Match Funds).			
Summary budget table completed (Leasing, Rental Assistance, Supportive Services, Operating Costs, HMIS, Administrative Costs, Total Grant Request).		7	
Match Funds: sources of matching funds documented (25% of awarded grant amount minus leasing), with match commitment letter attached		5	*Applies to every project type, including HMIS.*

GRAND TOTAL	**0**	**104**	

FY26 PWA CoC Scoring Tool — Rapid Re-Housing (RRH)

Mirrors application Sections 7 (General Questions) and 8.2. Enter points awarded in column B.

Organization Name:	
Project Name:	
Reviewer Name:	

Question	Score	Max Pts	Notes
7.1 Experience			**0 / 18**
Every applicant completes this subsection.			
Describe your agency's experience with this program type, including current programs operated, number of participants, and scope. (Approx. 300 words)		3	
Provide examples of outcome data from similar programs, including employment income outcomes and prevention of returns to homelessness. (Approx. 200 words)		3	
Describe your organization's accreditations and licensures. (Approx. 150 words)		2	
Describe staff training requirements and ongoing development. (Approx. 200 words)		2	
Describe how people with lived experience are included in decision-making. (Approx. 150 words)		2	
Does your organization currently manage any federal funding? (Yes/No)		1	
Describe your agency's internal fiscal management systems. (Approx. 200 words)		2	
Audit history: independent audit in past 24 months, any findings/sanctions, and resolution steps if unresolved (combined across all 3 audit questions).		3	
7.2 Design of Housing & Supportive Services			**0 / 6**
Applies to all types except HMIS.			

Summarize the scope of the project: target population, housing/services overview, program design, anticipated persons/households served, coordination, use of CoC funds. (Approx. 300 words / 2,000 char limit)		2	
Describe why the scattered-site or project-based design was chosen and how it supports target population needs. (Approx. 200 words)		2	
Eligible Support Services table: provider and frequency for each applicable service.		2	

7.3 Mainstream Resources, Coordinated Entry & Cost Reasonableness — 0 / 29

Cross-cutting items that apply to this project type, asked once in the application's Section 7.3.

Explain how the project will be supplemented with resources from other public or private sources (mainstream health, social, employment programs)		15	*HUD Threshold. Limit 1,000 characters.*
Will your project participate in the CoC's Coordinated Entry (CES) System (or alternate process for victim service providers)? Describe how		6	*HUD Threshold. Limit 1,000 characters.*
Describe your plan for making substance use disorder treatment available on-site and/or easily accessible, including 24/7 access to detox/residential/inpatient care and unit participation-ratio fields.		6	
Prohibiting Illicit Drug Enablement: attestation and remedies narrative for housing/SSO projects.		2	*HUD Threshold. Limit 1,000 characters.*

7.4 Implementation — 0 / 9

Every applicant completes this subsection.

Describe pre-grant-start readiness activities and 60/120/180-day work plan and goals. (Approx. 300 words)		3	
Project milestone schedule (days from grant agreement execution), consistent with 12/24-month statutory deadlines.		2	
Specific metrics to track implementation/outcomes, including employment income gains and prevention of returns to homelessness. (Approx. 150 words)		2	

1–2 examples of program changes made as a result of outcome data in other programs. (Approx. 200 words)		2	

8.2 Rapid Re-Housing (RRH) — 0 / 28

RRH-specific questions.

Describe how tenant-based rental assistance will help achieve self-sufficiency within 24 months.		7	*HUD Threshold. Limit 1,000 characters.*
Describe how supportive services will ensure participants obtain self-sufficiency and exit homelessness.		10	*HUD Threshold. Limit 1,000 characters.*
Describe outcome history or plan for ≥50% exits to permanent housing within 24 months and ≥50% with employment income.		7	*HUD Threshold. Limit 1,000 characters.*
Demonstrate that average cost per household served is reasonable (2 CFR 200.404).		4	

7.6 Financials — 0 / 12

Every applicant completes this subsection (including HMIS for Match Funds).

Summary budget table completed (Leasing, Rental Assistance, Supportive Services, Operating Costs, HMIS, Administrative Costs, Total Grant Request).		7	
Match Funds: sources of matching funds documented (25% of awarded grant amount minus leasing), with match commitment letter attached		5	*Applies to every project type, including HMIS.*

GRAND TOTAL	**0**	**102**

FY26 PWA CoC Scoring Tool — Transitional Housing (TH)

Mirrors application Sections 7 (General Questions) and 8.3. Enter points awarded in column B.

Organization Name:	
Project Name:	
Reviewer Name:	

Question	Score	Max Pts	Notes
7.1 Experience			**0 / 23**
Every applicant completes this subsection.			
Describe your agency's experience with this program type, including current programs operated, number of participants, and scope. (Approx. 300 words)		3	
Provide examples of outcome data from similar programs, including employment income outcomes and prevention of returns to homelessness. (Approx. 200 words)		8	*HUD Threshold for Transitional Housing: 3 pts base + 5 pts TH-specific = 8 pts max.*
Describe your organization's accreditations and licensures. (Approx. 150 words)		2	
Describe staff training requirements and ongoing development. (Approx. 200 words)		2	
Describe how people with lived experience are included in decision-making. (Approx. 150 words)		2	
Does your organization currently manage any federal funding? (Yes/No)		1	
Describe your agency's internal fiscal management systems. (Approx. 200 words)		2	
Audit history: independent audit in past 24 months, any findings/sanctions, and resolution steps if unresolved (combined across all 3 audit questions).		3	
7.2 Design of Housing & Supportive Services			**0 / 6**
Applies to all types except HMIS.			

Summarize the scope of the project: target population, housing/services overview, program design, anticipated persons/households served, coordination, use of CoC funds. (Approx. 300 words / 2,000 char limit)		2	
Describe why the scattered-site or project-based design was chosen and how it supports target population needs. (Approx. 200 words)		2	
Eligible Support Services table: provider and frequency for each applicable service.		2	

7.3 Mainstream Resources, Coordinated Entry & Cost Reasonableness — 0 / 29

Cross-cutting items that apply to this project type, asked once in the application's Section 7.3.

Explain how the project will be supplemented with resources from other public or private sources (mainstream health, social, employment programs)		15	*HUD Threshold. Limit 1,000 characters.*
Will your project participate in the CoC's Coordinated Entry (CES) System (or alternate process for victim service providers)? Describe how		6	*HUD Threshold. Limit 500 characters.*
Describe your plan for making substance use disorder treatment available on-site and/or easily accessible, including 24/7 access to detox/residential/inpatient care and unit participation-ratio fields.		6	
Prohibiting Illicit Drug Enablement: attestation and remedies narrative for housing/SSO projects.		2	*HUD Threshold. Limit 1,000 characters.*

7.4 Implementation — 0 / 9

Every applicant completes this subsection.

Describe pre-grant-start readiness activities and 60/120/180-day work plan and goals. (Approx. 300 words)		3	
Project milestone schedule (days from grant agreement execution), consistent with 12/24-month statutory deadlines.		2	
Specific metrics to track implementation/outcomes, including employment income gains and prevention of returns to homelessness. (Approx. 150 words)		2	

1–2 examples of program changes made as a result of outcome data in other programs. (Approx. 200 words)		2	

8.3 Transitional Housing (TH) — 0 / 45

TH-specific questions.

Explain how the project will provide/partner to provide eligible supportive services.		10	*HUD Threshold. Limit 1,000 characters.*
Explain prior experience helping individuals/families exit homelessness within 24 months, or plan to do so.		7	*HUD Threshold. Limit 1,000 characters.*
Explain plan to ensure ≥50% positive exits within 24 months and ≥50% with employment income.		7	*HUD Threshold. Limit 1,000 characters.*
Describe how the project will assess the service needs of program participants.		5	*HUD Threshold. Limit 1,000 characters.*
Demonstrate individualized services resulting in ≥20 hrs/week of engagement for all participants.		5	*HUD Threshold. Limit 1,000 characters.*
Service agreement attached demonstrating required participation in supportive services.		*see note*	*HUD Threshold (attachment-based; verify document is attached). Not separately scored as a narrative*
Combined service plans question: services/when/by whom + participant goals/strategies/target dates. Limit 1,500 characters.		8	
Demonstrate that average cost per household served is reasonable (2 CFR 200.404).		3	

7.6 Financials — 0 / 12

Every applicant completes this subsection (including HMIS for Match Funds).

Summary budget table completed (Leasing, Rental Assistance, Supportive Services, Operating Costs, HMIS, Administrative Costs, Total Grant Request).		7	

Match Funds: sources of matching funds documented (25% of awarded grant amount minus leasing), with match commitment letter attached		5	*Applies to every project type, including HMIS.*

GRAND TOTAL	**0**	**124**

FY26 PWA CoC Scoring Tool — Supportive Services Only — Standalone

Mirrors application Sections 7 (General Questions) and 8.4. Enter points awarded in column B.

Organization Name:	
Project Name:	
Reviewer Name:	

Question	Score	Max Pts	Notes
7.1 Experience			**0 / 18**
Every applicant completes this subsection.			
Describe your agency's experience with this program type, including current programs operated, number of participants, and scope. (Approx. 300 words)		3	
Provide examples of outcome data from similar programs, including employment income outcomes and prevention of returns to homelessness. (Approx. 200 words)		3	
Describe your organization's accreditations and licensures. (Approx. 150 words)		2	
Describe staff training requirements and ongoing development. (Approx. 200 words)		2	
Describe how people with lived experience are included in decision-making. (Approx. 150 words)		2	
Does your organization currently manage any federal funding? (Yes/No)		1	
Describe your agency's internal fiscal management systems. (Approx. 200 words)		2	
Audit history: independent audit in past 24 months, any findings/sanctions, and resolution steps if unresolved (combined across all 3 audit questions).		3	
7.2 Design of Housing & Supportive Services			**0 / 6**
Applies to all types except HMIS.			

Summarize the scope of the project: target population, housing/services overview, program design, anticipated persons/households served, coordination, use of CoC funds. (Approx. 300 words / 2,000 char limit)		2	
Describe why the scattered-site or project-based design was chosen and how it supports target population needs. (Approx. 200 words)		2	
Eligible Support Services table: provider and frequency for each applicable service.		2	

7.3 Mainstream Resources, Coordinated Entry & Cost Reasonableness — 0 / 23

Cross-cutting items that apply to this project type, asked once in the application's Section 7.3.

Explain how the project will be supplemented with resources from other public or private sources (mainstream health, social, employment programs)		15	*HUD Threshold. Limit 1,000 characters.*
Will your project participate in the CoC's Coordinated Entry (CES) System (or alternate process for victim service providers)? Describe how		6	*HUD Threshold. Limit 1,000 characters.*
Prohibiting Illicit Drug Enablement: attestation and remedies narrative for housing/SSO projects.		2	*HUD Threshold. Limit 1,000 characters.*

7.4 Implementation — 0 / 9

Every applicant completes this subsection.

Describe pre-grant-start readiness activities and 60/120/180-day work plan and goals. (Approx. 300 words)		3	
Project milestone schedule (days from grant agreement execution), consistent with 12/24-month statutory deadlines.		2	
Specific metrics to track implementation/outcomes, including employment income gains and prevention of returns to homelessness. (Approx. 150 words)		2	
1–2 examples of program changes made as a result of outcome data in other programs. (Approx. 200 words)		2	

8.4 Supportive Services Only — Standalone			0 / 30
SSO-Standalone-specific questions.			
Service agreement attached demonstrating required participation in supportive services (24 CFR 578.75(h)).		*see note*	*HUD Threshold (attachment-based; verify document is attached). Not separately scored as a narrative*
Explain why the project is necessary to assist people exiting homelessness and addressing barriers; annual needs assessment plan		10	*HUD Threshold. Limit 1,000 characters.*
Explain the proposed strategy for providing supportive services, including to unsheltered and hard-to-engage participants.		14	*HUD Threshold. Limit 1,000 characters.*
Demonstrate that average cost per household served is reasonable (2 CFR 200.404).		6	

7.6 Financials			0 / 12
Every applicant completes this subsection (including HMIS for Match Funds).			
Summary budget table completed (Leasing, Rental Assistance, Supportive Services, Operating Costs, HMIS, Administrative Costs, Total Grant Request).		7	
Match Funds: sources of matching funds documented (25% of awarded grant amount minus leasing), with match commitment letter attached		5	*Applies to every project type, including HMIS.*

GRAND TOTAL	0	98	

FY26 PWA CoC Scoring Tool — Supportive Services Only — Street Outreach

Mirrors application Sections 7 (General Questions) and 8.5. Enter points awarded in column B.

Organization Name:	
Project Name:	
Reviewer Name:	

Question	Score	Max Pts	Notes
7.1 Experience			**0 / 18**
Every applicant completes this subsection.			
Describe your agency's experience with this program type, including current programs operated, number of participants, and scope. (Approx. 300 words)		3	
Provide examples of outcome data from similar programs, including employment income outcomes and prevention of returns to homelessness. (Approx. 200 words)		3	
Describe your organization's accreditations and licensures. (Approx. 150 words)		2	
Describe staff training requirements and ongoing development. (Approx. 200 words)		2	
Describe how people with lived experience are included in decision-making. (Approx. 150 words)		2	
Does your organization currently manage any federal funding? (Yes/No)		1	
Describe your agency's internal fiscal management systems. (Approx. 200 words)		2	
Audit history: independent audit in past 24 months, any findings/sanctions, and resolution steps if unresolved (combined across all 3 audit questions).		3	
7.2 Design of Housing & Supportive Services			**0 / 6**
Applies to all types except HMIS.			

Summarize the scope of the project: target population, housing/services overview, program design, anticipated persons/households served, coordination, use of CoC funds. (Approx. 300 words / 2,000 char limit)		2	
Describe why the scattered-site or project-based design was chosen and how it supports target population needs. (Approx. 200 words)		2	
Eligible Support Services table: provider and frequency for each applicable service.		2	

7.3 Mainstream Resources, Coordinated Entry & Cost Reasonableness — 0 / 23

Cross-cutting items that apply to this project type, asked once in the application's Section 7.3.

Explain how the project will be supplemented with resources from other public or private sources (mainstream health, social, employment programs)		15	*HUD Threshold. Limit 1,000 characters.*
Will your project participate in the CoC's Coordinated Entry (CES) System (or alternate process for victim service providers)? Describe how		6	*HUD Threshold. Limit 1,000 characters.*
Prohibiting Illicit Drug Enablement: attestation and remedies narrative for housing/SSO projects.		2	*HUD Threshold. Limit 1,000 characters.*

7.4 Implementation — 0 / 9

Every applicant completes this subsection.

Describe pre-grant-start readiness activities and 60/120/180-day work plan and goals. (Approx. 300 words)		3	
Project milestone schedule (days from grant agreement execution), consistent with 12/24-month statutory deadlines.		2	
Specific metrics to track implementation/outcomes, including employment income gains and prevention of returns to homelessness. (Approx. 150 words)		2	
1–2 examples of program changes made as a result of outcome data in other programs. (Approx. 200 words)		2	

8.5 Supportive Services Only — Street Outreach			0 / 30
SSO-Street Outreach-specific questions.			
Demonstrate a strategy for providing supportive services, including to unsheltered and hard-to-engage participants.		7	*HUD Threshold. Limit 1,000 characters.*
Demonstrate history of partnering with first responders/law enforcement; cooperation, not interference, with local enforcement		10	*HUD Threshold. Limit 1,000 characters.*
Explain outreach experience (24 CFR 578.53(e)(13)) and effectiveness helping people exit unsheltered locations.		7	*HUD Threshold. Limit 1,000 characters.*
Describe how street outreach will be conducted: frequency, location, staffing structure.		6	

7.6 Financials			0 / 12
Every applicant completes this subsection (including HMIS for Match Funds).			
Summary budget table completed (Leasing, Rental Assistance, Supportive Services, Operating Costs, HMIS, Administrative Costs, Total Grant Request).		7	
Match Funds: sources of matching funds documented (25% of awarded grant amount minus leasing), with match commitment letter attached		5	*Applies to every project type, including HMIS.*

GRAND TOTAL	0	98	

FY26 PWA CoC Scoring Tool — Supportive Services Only — Coordinated Entry

Mirrors application Sections 7 (General Questions) and 8.6. Enter points awarded in column B.

Organization Name:	
Project Name:	
Reviewer Name:	

Question	Score	Max Pts	Notes
7.1 Experience			**0 / 18**
Every applicant completes this subsection.			
Describe your agency's experience with this program type, including current programs operated, number of participants, and scope. (Approx. 300 words)		3	
Provide examples of outcome data from similar programs, including employment income outcomes and prevention of returns to homelessness. (Approx. 200 words)		3	
Describe your organization's accreditations and licensures. (Approx. 150 words)		2	
Describe staff training requirements and ongoing development. (Approx. 200 words)		2	
Describe how people with lived experience are included in decision-making. (Approx. 150 words)		2	
Does your organization currently manage any federal funding? (Yes/No)		1	
Describe your agency's internal fiscal management systems. (Approx. 200 words)		2	
Audit history: independent audit in past 24 months, any findings/sanctions, and resolution steps if unresolved (combined across all 3 audit questions).		3	
7.2 Design of Housing & Supportive Services			**0 / 6**
Applies to all types except HMIS.			

Summarize the scope of the project: target population, housing/services overview, program design, anticipated persons/households served, coordination, use of CoC funds. (Approx. 300 words / 2,000 char limit)		2	
Describe why the scattered-site or project-based design was chosen and how it supports target population needs. (Approx. 200 words)		2	
Eligible Support Services table: provider and frequency for each applicable service.		2	

7.3 Mainstream Resources, Coordinated Entry & Cost Reasonableness — 0 / 2

Cross-cutting items that apply to this project type, asked once in the application's Section 7.3.

Prohibiting Illicit Drug Enablement: attestation and remedies narrative for housing/SSO projects.		2	*HUD Threshold. Limit 1,000 characters.*

7.4 Implementation — 0 / 9

Every applicant completes this subsection.

Describe pre-grant-start readiness activities and 60/120/180-day work plan and goals. (Approx. 300 words)		3	
Project milestone schedule (days from grant agreement execution), consistent with 12/24-month statutory deadlines.		2	
Specific metrics to track implementation/outcomes, including employment income gains and prevention of returns to homelessness. (Approx. 150 words)		2	
1–2 examples of program changes made as a result of outcome data in other programs. (Approx. 200 words)		2	

8.6 Supportive Services Only — Coordinated Entry — 0 / 45

SSO-Coordinated Entry-specific questions. This project type does not use most of Section 7.3 (it operates the CES system itself); only Prohibiting Illicit Drug Enablement applies there.

Explain how CES is easily available/reachable for all persons, including persons with disabilities.		9	*HUD Threshold. Limit 1,000 characters.*
Explain advertising strategy targeting households with highest needs.		9	*HUD Threshold. Limit 1,000 characters.*
Describe the use of a standardized assessment process.		9	*HUD Threshold. Limit 1,000 characters.*
Describe how participants are directed to appropriate housing/services.		9	*HUD Threshold. Limit 1,000 characters.*
Describe how the project will improve CES performance/effectiveness: gaps, strategies, outcomes, benchmarks.		9	

7.6 Financials			**0 / 12**
Every applicant completes this subsection (including HMIS for Match Funds).			
Summary budget table completed (Leasing, Rental Assistance, Supportive Services, Operating Costs, HMIS, Administrative Costs, Total Grant Request).		7	
Match Funds: sources of matching funds documented (25% of awarded grant amount minus leasing), with match commitment letter attached		5	*Applies to every project type, including HMIS.*

GRAND TOTAL	**0**	**92**	

FY26 PWA CoC Scoring Tool — HMIS Expansion

Mirrors application Sections 7 (General Questions) and 8.7. Enter points awarded in column B.

Organization Name:	
Project Name:	
Reviewer Name:	

Question	Score	Max Pts	Notes
7.1 Experience			**0 / 18**
Every applicant completes this subsection.			
Describe your agency's experience with this program type, including current programs operated, number of participants, and scope. (Approx. 300 words)		3	
Provide examples of outcome data from similar programs, including employment income outcomes and prevention of returns to homelessness. (Approx. 200 words)		3	
Describe your organization's accreditations and licensures. (Approx. 150 words)		2	
Describe staff training requirements and ongoing development. (Approx. 200 words)		2	
Describe how people with lived experience are included in decision-making. (Approx. 150 words)		2	
Does your organization currently manage any federal funding? (Yes/No)		1	
Describe your agency's internal fiscal management systems. (Approx. 200 words)		2	
Audit history: independent audit in past 24 months, any findings/sanctions, and resolution steps if unresolved (combined across all 3 audit questions).		3	
7.4 Implementation			**0 / 9**

Every applicant completes this subsection.

Describe pre-grant-start readiness activities and 60/120/180-day work plan and goals. (Approx. 300 words)		3	
Project milestone schedule (days from grant agreement execution), consistent with 12/24-month statutory deadlines.		2	
Specific metrics to track implementation/outcomes, including employment income gains and prevention of returns to homelessness. (Approx. 150 words)		2	
1–2 examples of program changes made as a result of outcome data in other programs. (Approx. 200 words)		2	

8.7 HMIS Expansion — 0 / 79

HMIS-specific questions. HMIS does not use Section 7.2 or 7.3.

Describe the agency's experience administering an HMIS project and prior successes. Limit 1,000 characters.		8	
Describe how HMIS funds requested will be allocated and the rationale. Limit 1,000 characters.		9	
Describe alignment with CoC HMIS implementation priorities and goals. Limit 1,000 characters.		9	
Describe processes/workflows ensuring Universal Data Elements collection. Limit 1,000 characters.		9	
Describe data quality and consistency monitoring over time. Limit 1,000 characters.		9	
Describe the ability of the HMIS to un-duplicate client records. Limit 500 characters.		9	
Describe core HUD-required reports produced (e.g., APR, quarterly). Limit 1,000 characters.		9	

Describe other federal partner reporting (e.g., CAPER, ESG). Limit 1,000 characters.		8	
HMIS Expansion Budget Narrative. Limit 1,000 characters.		9	

7.6 Financials			**0 / 12**
Every applicant completes this subsection (including HMIS for Match Funds).			
Summary budget table completed (Leasing, Rental Assistance, Supportive Services, Operating Costs, HMIS, Administrative Costs, Total Grant Request).		7	
Match Funds: sources of matching funds documented (25% of awarded grant amount minus leasing), with match commitment letter attached		5	*Applies to every project type, including HMIS.*

GRAND TOTAL	**0**	**118**	

FY26 PWA CoC New Project Scoring Tool — HUD NOFO Rating & Ranking Crosswalk

Maximum points by project component type for objective criteria, system performance measures (SPM), returns to homelessness, employment income and supportive service participation requirements. Shows the new project types scored in the FY26 local competition (TH, SSO-Standalone, SSO-Coordinated Entry). SPMs apply only to TH, Street Outreach and permanent housing, so SPM columns are N/A for SSO-Standalone and SSO-Coordinated Entry. All values are formulas that read columns E–H on each project-type tab.

Project Component Type	Total Max Pts	Objective Pts	Objective %	Meets 50%?	SPM Pts	SPM %	Meets 25%?	Returns Pts	Employment Income Pts	Supportive Service Participation Pts	Returns considered?	Employment considered?	Supportive services considered?
Transitional Housing (TH)	124	70	56%	**Yes**	67	54%	**Yes**	10	17	5	Yes	Yes	Yes
SSO — Standalone	98	61	62%	**Yes**	N/A	N/A	**N/A**	5	5	0	Yes	Yes	N/A
SSO — Coordinated Entry	92	34	37%	**No**	N/A	N/A	**N/A**	5	5	0	Yes	Yes	N/A
Overall Average (3 project types scored; SPM excludes N/A types)	**104.7**	**55.0**	**51.9%**	**Yes**	**67.0**	**54.0%**	**Yes**	**6.7**	**9.0**	**1.7**			
Overall (total points across the 3 project types scored)	**314**	**165**	**52.5%**	**Yes**	**67**	**54.0%**	**Yes**	**20**	**27**	**5**			

Includes only the new project types scored in the FY26 local competition: TH, SSO-Standalone and SSO-Coordinated Entry. Overall Average = simple average of the 3 project-type percentages (SPM applies only to TH). Overall (total points) = combined points ÷ combined maximum points (SPM denominator excludes N/A types). Returns and employment income are scored together in shared items (7.1 outcome data; 7.4 outcome metrics), so the same points appear in both columns. N/A = not a housing project (checklist item 6 applies to TH, PSH and RRH). "Threshold only" = required service-participation agreement is checked as a HUD threshold but carries 0 points in this tool.

Overall New Project Scoring Tool Summary

Overall Measure	Objective Criteria	System Performance Measures (SPM)	How it is calculated
Average of the project types	**51.9% (55.0 of 104.7 pts on average)**	**54.0% (TH only; SPMs N/A for SSO-Standalone and SSO-CE)**	Simple average of each project type's percentage; every type counts equally. SPM average excludes N/A types.
Total points across the 3 types	**52.5% (165 of 314 pts)**	**54.0% (67 of 124 pts)**	Combined points ÷ combined maximum points. SPM denominator includes only types where SPMs apply.
HUD minimum	**50%**	**25%**	HUD CoC NOFO rating & ranking standard.
Meets?	**Yes**	**Yes**	Yes when both the average and total-points calculations meet the minimum.

HUD CoC NOFO Rating & Ranking Checklist — New Project Scoring Tool

Checklist Item	New Project Tool	Basis / Gap
1. Established total points available for each project application type.	**Yes**	Every new project type scored has a maximum: TH 124, SSO-Standalone 98, SSO-Coordinated Entry 92 points.
2. At least 50% of total available points based on objective criteria.	**Yes**	Overall: 51.9% average and 52.5% of total points (165 of 314). By type: TH 56%, SSO-Standalone 62%, SSO-CE 37%.
3. At least 25% of total available points based on system performance measures.	**Yes**	SPMs apply only to TH among the new types scored (N/A for SSO-Standalone and SSO-CE). TH: 67 of 124 pts (54.0%). SPM points = SPM-aligned items plus scored HUD Threshold items (CoC classification).
4. Considered returns to homelessness (TH, PSH, RRH).	**Yes**	TH items 7.1 (outcome data) and 7.4 (outcome metrics): 10 pts. TH is the only new housing type scored.

5. Considered employment income (TH, PSH, RRH).	**Yes**	TH: 17 pts (7.1, 7.4 and 8.3 ≥50% employment income item).
6. Considered supportive service participation requirements (TH, PSH, RRH).	**Yes**	TH: 5 pts for ≥20 hrs/week service engagement; the service agreement attachment is a HUD threshold.
A. At least one criterion relates to improving system performance (CoC Bonus / DV Bonus eligibility).	**Yes**	TH has 67 SPM points. SPMs are N/A for SSO-Standalone and SSO-CE.
B/D. Uploaded tool(s) cover all component types and show required maximum points.	**Yes**	Combined with the renewal tool, the upload covers renewal PSH/RRH plus new TH, SSO-Standalone and SSO-Coordinated Entry. Upload this Crosswalk tab and those project-type tabs.

FY 2026

VA-604 – Prince William Area Continuum of Care

1D-2c. Local Competition Selection Results

Documents include the following:

- **Final Project Scores Renewal & New Project Applications**

PWA CoC FY26 HUD Applicants & Prioritization														
Grant #	**Project Name**	**Project Type**	**Recipient Name**	**Amount Requested to HUD**	**Reallocated**	**Performance Points Available***	**Performance Points Earned**	**Bonus Points Earned**	**Score**	**Rank**	**Project Type** (New, Renewal, Transition)	**Status** (Accepted/ Rejected/Reallocated)	**Funding Source**	**Reason for Rejection**
TIER 1 PROJECTS														
VA0439	VA0439 ACTS DV Bonus	RRH	Action in Community Through Service of Prince William	$ 425,414.00	$ -	100	91	2.47	**93%**	**1**	**Renewal**	**Accepted**	**CoC ARD**	**N/A**
VA0127	VA0127 PWA PASS PSH	PSH	Streetlight Community Outreach Ministries	$ 358,865.00	$ -	100	85	3.09	**88%**	**2**	**Renewal**	**Accepted**	**CoC ARD**	**N/A**
VA0132†	VA0132 PWA HMIS	HMIS	Prince William County Dept. of Social Services (PWC DSS)	$ 41,480.00	$ -	N/A	N/A	N/A	**N/A**	**3**	**Renewal**	**Accepted**	**CoC ARD**	**N/A**
VA0324	VA0324 ACTS RRH	RRH	Action in Community Through Service of Prince William	$ 246,093.00	$ -	100	84	1.48	**85%**	**4**	**Renewal**	**Accepted**	**CoC ARD**	**N/A**
SUB-TOTAL				**$ 1,071,852.00**	**$ -**									
TIER 2 PROJECTS														
VA0324	VA0324 ACTS RRH	RRH	Action in Community Through Service of Prince William	$ 774.00	$ -	100	84	1.48	**85%**	**4**	**Renewal**	**Accepted**	**CoC ARD**	**N/A**
VA0398	VA0398 PWA PSH Bonus	PSH	Pathway Homes	$ -	$ (496,153.00)	N/A	N/A	N/A	**N/A**	**Not Ranked**	**Transition**	**Fully Reallocated**	**CoC Reallocation**	**N/A**
N/A	Transitional Housing	TH	Pathway Homes	$ 496,153.00	$ 496,153.00	124	116	N/A	**93%**	**5**	**Transition**	**Accepted**	**Reallocation**	**N/A**
VA0130	VA0130 PWA Leasing	PSH	Good Shepherd Housing Foundation	$ -	$ (217,641.00)	N/A	N/A	N/A	**N/A**	**Not Ranked**	**Renewal**	**Fully Reallocated**	**N/A**	**N/A**
N/A	PWA Coordinated Entry	SSO - CE	Prince William County DSS	$ 263,000.00	$ 217,641.00	92	81.75	N/A	**89%**	**6**	**New**	**Accepted**	**CoC Bonus & Reallocation**	**N/A**
N/A	KALMA Foundation Transitional Housing Program for Survivors of Domestic Violence	DV TH	KALMA	$ 235,600.00	$ -	124	99.5	N/A	**80%**	**7**	**New**	**Accepted**	**DV Bonus**	**N/A**
N/A	Transitional Housing	TH	SLS Home Solutions	$ 250,000.00	$ -	124	97.5	N/A	**79%**	**8**	**New**	**Accepted**	**CoC Bonus**	**N/A**
N/A	A Heart For People: Housing Stability & Recovery Navigation Center	SSO	The Church on the Rock Ministries	$ 213,852.00		98	76.5	N/A	**78%**	**9**	**New**	**Accepted**	**CoC Bonus**	**N/A**
N/A	Bright Path & Senior Nest Transitional Housing	TH	Bright Path & Senior Nest	N/A	$ -	124	86.5	N/A	**70%**	**Not Ranked**	**New**	**Rejected**	**N/A**	**Did not meet Threshold**
N/A	Bright Path & Senior Nest Senior Supportive Services	SSO	Bright Path & Senior Nest	N/A	$ -	98	67.75	N/A	**69%**	**Not Ranked**	**New**	**Rejected**	**N/A**	**Did not meet Threshold**
SUB-TOTAL				**$ 1,245,527.00**	**$ -**									
Non-Competitive/Non-Ranked Projects														
CoC Planning	CoC Planning	CoC	Prince William County Dept. of Social Services (PWC DSS)	$ 169,737.00	$ -	N/A	N/A	N/A	**N/A**	**Not Ranked**	**Planning**	**Accepted**	**CoC Planning**	**N/A**
SUB-TOTAL				**$ 169,737.00**	**$ -**									
GRAND TOTAL				**$ 2,487,116.00**	**$ -**	**N/A**	**N/A**		**N/A**					

** For some projects the number of "Possible Points" is reduced as the project did not have data to be scored for certain measures. This does not mean the provider did not submit data, it simply means the data does not exist. For example, some of the PSH projects did not have any exits during the reporting period therefore there's nothing to score for exit destination outcomes.*

† Project "held harmless"

- VA0132 † supports the entire CoC's HMIS and HMIS participation by CoC-funded projects is required under the CoC Program.

†† Project combined in FY25

- VA0127 &VA0133 combined for HUD FY25, Streetlight Community Outreach Ministries (SCOM) Permanent Supportive Housing (PSH) projects. This change was applied as the provider combined these projects and are now reported as one (under VA0127) on the current FY25 HUD Grant Inventory Worksheet (GIW).

‡ Project is split between Tier I and Tier II

HUD ALLOWED AMOUNTS

ARD Amount	$	1,786,420.00	PPRN - $3,394,741
Tier 1	$	1,071,852.00	FPRN - $3,394,741
Tier 2	$	1,902,727.00	DV Bonus - $678,948
CoC Reallocation + CoC Bonus	$	1,223,779.00	
ARD in Tier 2	$	714,568.00	CoC Bonus - $509,211 + GSHF Reallocation $217,641 = $726,852
CoC Bonus	$	509,211.00	UFA Costs - $101,842
DV Bonus	$	678,948.00	

PWA CoC Amounts to be Submitted

		Project Totals		Remaining Amount
Tier 1	$	1,071,852.00	$	-
Tier 2	$	963,226.00	$	939,501.00
CoC Reallocation + CoC Bonus	$	727,626.00	$	496,153.00
Straddle Project Amount	$	774.00		
Reallocation - Transition	$	-		
CoC Bonus + Remaining Reallocation	$	726,852.00		
DV Bonus	$	235,600.00	$	443,348.00

FY 2026

VA-604 – Prince William Area

Continuum of Care

2A-8b. FY 2026 HDX Competition Report

Documents include the following:

- **PWA CoC – 2026 HDX Competition Report**

2025 HDX Competition Report

2026 Competition Report - Summary

VA-604 - Prince William 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.

2026 Competition Report - LSA Summary & Usability Status

VA-604 - Prince William 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

2026 Competition Report - SPM Data

VA-604 - Prince William 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	797	109.5	74.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	830	126.6	82.0

2026 Competition Report - SPM Data

VA-604 - Prince William 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")	810	307.4	175.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to "housing move in")	843	323.8	182.0

2026 Competition Report - SPM Data

VA-604 - Prince William 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	36	5	13.9%	3	8.3%	5	13.9%	13	36.1%
Exit was from ES	290	25	8.6%	22	7.6%	21	7.2%	68	23.5%
Exit was from TH	1	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	126	8	6.4%	6	4.8%	19	15.1%	33	26.2%
TOTAL Returns to Homelessness	453	38	8.4%	31	6.8%	45	9.9%	114	25.2%

2026 Competition Report - SPM Data

VA-604 - Prince William 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	835
Emergency Shelter Total	802
Safe Haven Total	0
Transitional Housing Total	43

2026 Competition Report - SPM Data

VA-604 - Prince William 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)	24
Number of adults with increased earned income	1
Percentage of adults who increased earned income	4.2%

2026 Competition Report - SPM Data

VA-604 - Prince William 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)	24
Number of adults with increased non-employment cash income	15
Percentage of adults who increased non-employment cash income	62.5%

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

Metric	Value
Universe: Number of adults (system stayers)	24
Number of adults with increased total income	16
Percentage of adults who increased total income	66.7%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	16
Number of adults who exited with increased earned income	2
Percentage of adults who increased earned income	12.5%

2026 Competition Report - SPM Data

VA-604 - Prince William 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)	16
Number of adults who exited with increased non-employment cash income	5
Percentage of adults who increased non-employment cash income	31.3%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	16
Number of adults who exited with increased total income	6
Percentage of adults who increased total income	37.5%

2026 Competition Report - SPM Data

VA-604 - Prince William 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.	693
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.	171
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)	522

2026 Competition Report - SPM Data

VA-604 - Prince William 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.	743
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.	214
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.)	529

2026 Competition Report - SPM Data

VA-604 - Prince William 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	358
Of persons above, those who exited to temporary & some institutional destinations	81
Of the persons above, those who exited to permanent housing destinations	28
% Successful exits	30.5%

2026 Competition Report - SPM Data

VA-604 - Prince William 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	622
Of the persons above, those who exited to permanent housing destinations	271
% Successful exits	43.6%

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	52
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	49
% Successful exits/retention	94.2%

2026 Competition Report - SPM Data

VA-604 - Prince William 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)	805	43	57	200	124
Total Leavers (HMIS)	667	6	12	115	92
Destination of Don't Know, Refused, or Missing (HMIS)	122	0	2	1	11
Destination Error Rate (Calculated)	18.3%	0.0%	16.7%	0.9%	12.0%

2026 Competition Report - SPM Notes

VA-604 - Prince William County CoC

FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Notes For Each SPM Measure

Measure	Notes
Measure 1	No comments - data matches SPM report from our HMIS
Measure 2	No comments - data matches SPM report from our HMIS
Measure 3	No comments - data matches SPM report from our HMIS
Measure 4	No comments - data matches SPM report from our HMIS as well as the project CoC APR.
Measure 5	No comments - data matches SPM report from our HMIS
Measure 6	No Notes. Measure 6 was not applicable to CoCs in this reporting period.
Measure 7	No comments - data matches SPM report from our HMIS
Data Quality	Most of the unknown exit destinations for ES are from our hypothermia shelters. Counts match our SPM report in HMIS.

2025 HDX Competition Report

2026 Competition Report - HIC Summary

VA-604 - Prince William 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	232	194	214	0	214	90.7%
SH	0	0	0	0	0	NA
TH	54	54	54	0	54	100.0%
RRH	109	62	79	0	79	78.5%
PSH	194	44	194	0	194	22.7%
OPH	48	6	48	0	48	12.5%
Total	**637**	**360**	**589**	**0**	**589**	**61.1%**

2026 Competition Report

VA-604 - Prince William Count

For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, VSP Beds in an HMIS-Comparable Database	Total Year-Round, Current, VSP Beds	Removed From Denominator: OPH EHV† Beds or Beds Affected by Natural Disaster**	Adjusted*** Total Year-Round Current, VSP Beds	HMIS Comparable Bed Coverage Rate for VSP Beds
ES	232	18	18	0	18	100.00%
SH	0	0	0	0	0	NA
TH	54	0	0	0	0	NA
RRH	109	30	30	0	30	100.00%
PSH	194	0	0	0	0	NA
OPH	48	0	0	0	0	NA
Total	**637**	**48**	**48**	**0**	**48**	**100.00%**

2025 HDX Competition Report

2026 Competition Report

VA-604 - Prince William Count

For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS-Comparable Database	Adjusted*** Total Year-Round, Current, Non-VSP and VSP Beds	HMIS and Comparable Database Coverage Rate
ES	232	212	232	91.38%
SH	0	0	0	NA
TH	54	54	54	100.00%
RRH	109	92	109	84.40%
PSH	194	44	194	22.68%
OPH	48	6	48	12.50%
Total	**637**	**408**	**637**	**64.05%**

2026 Competition Report - HIC Summary

VA-604 - Prince William 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.

2026 Competition Report - PIT Summary

VA-604 - Prince William County CoC

For PIT conducted in January/February of 2026

Submission Information

Date of PIT Count	Received HUD Waiver
2/4/2026	Yes

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	228	246	273
Safe Haven Total	0	0	0
Transitional Housing Total	28	32	33
Total Sheltered Count	256	278	306
Total Unsheltered Count	89	115	81
Total Sheltered and Unsheltered Count*	345	393	387

1) *Data included in this table reflect what was entered into HDX 2.0. This may differ from what was included in federal repo rts 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	21	45	62
Total Unsheltered Count	28	47	23
Total	49	92	85