

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-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

1A-2. Collaborative Applicant Name: George Washington Regional Commission

1A-3. CoC Designation: CA

1A-4. HMIS Lead: George Washington Regional Commission

1B. Coordination and Engagement–Accountable Structure and Participation

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

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- Frequently Asked Questions

1B-1.	Accountable Structure and Participation.	
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In the chart below for the period from June 1, 2025 to May 31, 2026:

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

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

	Entity	Participated in CoC Meetings	Number of Board Members
1.	Affordable Housing Developer(s)	Yes	1
2.	CDBG/HOME/ESG Entitlement Jurisdiction(s)	Yes	1
3.	Certified Community Behavioral Health Clinic (CCBHC)	Nonexistent	
4.	Community Mental Health Center (CMHC)	Yes	0
5.	Disability Advocate(s)	Yes	0
6.	Disability Service Organization(s)	Yes	0
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	1
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	1
9.	Faith-based Organization(s)	Yes	1
10.	Homeless or Formerly Homeless Person(s)	Yes	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	1
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	0
16.	Local Government Staff/Official(s)	Yes	3

17.	State Government Staff/Official(s)	Yes	0
18.	State or Local Elected Public Official(s)	Yes	0
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	Yes	0
23.	Other homeless subpopulation advocate(s)	Yes	2
24.	Other nonprofit homeless assistance provider(s)	Yes	3
25.	Other social service provider(s)	Yes	3
26.	Public Housing Agencies	Yes	0
27.	Recovery Housing or Sober Living Provider(s)	No	
28.	School Administrators/Homeless Liaison(s)	Yes	0
29.	School District(s)	Yes	0
30.	Street Outreach Team(s)	Yes	1
31.	Substance Abuse Advocate(s)	Yes	0
32.	Substance Abuse Service Organization(s)	Yes	0
33.	Universities	Yes	1
34.	Veteran Serving Organization(s)	Yes	1
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	Yes	0
40.	State Sexual Assault Coalition	Yes	0
41.	Youth Advocate(s)	Yes	2
42.	Youth Homeless Organization(s)	Yes	2
43.	Youth Service Provider(s)	Yes	2
44.	Other Homeless Assistance Provider(s)	Yes	3
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	0
	Other: (limit 50 characters)		
46.	HIV/AIDS Homeless Organizations	Yes	1
47.			

1B-2.	Open Invitation for New Members.	
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Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to invite new members to join the CoC at least annually.

(limit 2,500 characters)

The CoC maintains a transparent and publicly available process for inviting new members from throughout Planning District 16. Membership is open year-round to organizations and individuals with knowledge of homelessness or an interest in preventing and ending homelessness. New members are solicited continuously through a standing invitation on the CoC's public website. Potential members may join the CoC at any time by completing a new member application. Opportunities to join and participate in the CoC are also communicated through regular social media outreach, the CoC's monthly newsletter, and quarterly CoC information sessions. These multiple communication methods ensure that information about membership is publicly available and reaches stakeholders throughout the City of Fredericksburg and Caroline, King George, Spotsylvania, and Stafford counties. In addition to year-round open membership, the CoC conducts a formal solicitation for new members at least annually. The annual solicitation is publicly communicated and encourages participation from individuals and organizations representing the broad range of sectors and populations involved in preventing and ending homelessness. The CoC also conducts targeted outreach to strengthen representation. CoC members and staff extend personal invitations to individuals and organizations with skills, expertise, or perspectives needed to support the CoC's work and strategic priorities. CoC staff review membership representation and conduct outreach to sectors and populations that are missing or underrepresented. The CoC Program Coordinator also meets one-on-one with potential members to explain the CoC, opportunities for participation, and the process for becoming a member. Through its standing public invitation, annual membership solicitation, regular communications, information sessions, and targeted outreach, the CoC provides multiple transparent and accessible opportunities for new members to join and participate in the CoC.

1B-3.	CoC's Strategy to Solicit and Consider Opinions on Preventing and Ending Homelessness.	
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Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to solicit and consider opinions regarding the CoC's general performance, strategies, and priority setting process from a broad array of individuals and organizations that have knowledge of homelessness or an interest in preventing or ending homelessness in the CoC's geographic area.
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(limit 2,500 characters)

The CoC uses a transparent, ongoing process to solicit and consider community input regarding the CoC's general performance, strategies, and priority setting. CoC members and non-members are engaged through a robust committee structure that provides opportunities for input on strategic planning, system design, policy, funding priorities, community initiatives, and system performance. Quarterly CoC membership meetings and monthly committee meetings are open to the public and provide opportunities for feedback on items under consideration. Meetings are publicly advertised on the CoC website, and meeting materials are made available in advance. The CoC also uses public comment periods, community surveys, quarterly information and training sessions, and targeted stakeholder outreach to gather input. Public comment opportunities are communicated through the CoC website, monthly newsletter, email distribution lists, and other public communications. Summaries of feedback are presented during meetings and incorporated into the development and finalization of plans, policies, priorities, and strategies. The CoC seeks input from a broad array of individuals and organizations with knowledge of or an interest in preventing and ending homelessness, including people with lived experience; homeless assistance and victim service providers; local governments; affordable housing organizations; healthcare, behavioral health, and substance use providers; disability and mental health advocates; schools; law enforcement; faith-based organizations; veterans and youth-serving organizations; and other community partners. The CoC works to reduce barriers to participation. Meetings are available virtually, meeting facilities are ADA accessible, and public documents are made available electronically. The CoC also partners with the local Center for Independent Living to strengthen engagement of people with disabilities. Community input is considered as part of CoC decision-making rather than collected solely for informational purposes. For example, when developing its strategy to address unsheltered homelessness, the CoC presented the proposed approach at public meetings across its geographic area and released the proposal for public comment. Feedback received through the meetings and public comment process was considered and used to finalize the CoC's strategy.

1B-4.	Public Notification for Proposals from Organizations Not Previously Awarded CoC Program Funding.	
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Describe your CoC's transparent process to accept and consider proposals from organizations that have not previously received CoC Program funding including faith-based organizations.

(limit 2,500 characters)

The CoC conducts an open and transparent local competition that accepts and considers proposals from organizations that have not previously received CoC Program funding, including faith-based organizations. The CoC releases a local NOFO soliciting project applications for consideration for inclusion in the CoC Program Collaborative Application. The local NOFO specifically states that the CoC is open and willing to consider applications from organizations that have not previously received CoC Program funding. The opportunity is broadly publicized through the CoC website, email distribution lists, monthly newsletter, social media, and community stakeholder networks. The local NOFO provides information regarding available funding, eligible projects, application requirements, deadlines, and instructions for submitting an application. Following release of the local NOFO, CoC staff host a public, virtual information session to explain the funding opportunity, application and submission process, and answer applicant questions. The session is recorded and made available on the CoC website and YouTube. Technical assistance is available to all potential applicants throughout the competition so that unfamiliarity with the CoC Program or application process is not a barrier to participation. The CoC publicly releases the CoC Board-approved scoring tools used to evaluate applications. Projects meeting eligibility and threshold requirements are reviewed by the CoC Funding Committee using established criteria, including alignment with local needs and priorities, HUD priorities, organizational capacity, project quality, and strength of the application. The Funding Committee develops recommendations for CoC Board approval. The review and selection process is further described in the CoC's publicly available Funding Policies and Procedures. During this competition, the CoC received applications from organizations that had not previously received CoC Program funding. New and existing applicants are considered through the same established eligibility, threshold, review, and selection processes. Faith-based organizations are expressly eligible to participate in the local competition, and the CoC's existing portfolio includes a faith-based organization that has successfully competed for and received CoC Program funding. All competition notices, forms, scoring tools, and supporting materials are publicly available on the CoC website in accessible electronic formats.

1B-5	Plan for Comprehensive Strategies for Reducing Homelessness.
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Describe how your CoC will incorporate comprehensive strategies for reducing homelessness, including interventions in 42 U.S.C. 11386b(d) and other targeted projects for specific subpopulations, by providing a plan to address a gap in the CoC's current homelessness system.

(limit 2,500 characters)

The Fredericksburg Regional CoC has identified gaps in its Coordinated Entry (CE) system that limit its ability to consistently assess needs, prioritize households, connect people to appropriate interventions, and measure outcomes. Review of CE/HMIS data, including limitations identified through CE reporting, and provider feedback demonstrate the need to strengthen CE governance, prioritization, data collection, and referral pathways. Over the next 12 months, the CoC will implement a comprehensive CE improvement strategy. Activities will include establishing/restructuring a CE Committee; adopting a CE Governance Charter and updated prioritization decision matrix; revising assessment and referral procedures; improving HMIS configuration and CE reporting; and strengthening pathways to permanent supportive housing for persons experiencing chronic homelessness, rapid rehousing and other permanent housing.

The strategy will address the needs of individuals, families with children, youth and young adults, survivors of domestic violence, persons with disabilities, veterans, and people experiencing unsheltered homelessness. For families, the CoC will strengthen connections to TANF, SNAP, Medicaid/FAMIS, schools, child welfare, employment services, and other family-serving systems.

Within 3 months, the CoC will establish the CE governance structure and complete a review of CE workflows and data gaps. Within 6 months, it will adopt the Governance Charter, decision matrix, and revised referral procedures and begin HMIS configuration changes. Within 12 months, revised procedures will be fully implemented, 100% of participating CE providers will be trained, 100% of CE housing referrals will follow the adopted prioritization process, and CE APR configuration improvements will be completed. The CoC will establish baseline measures and monitor length of time homeless, permanent housing exits, returns to homelessness, and CE data completeness to establish measurable improvement targets.

GWRC, as CoC and HMIS Lead, will oversee implementation with the CoC Board, System Performance Committee, System Planning Committee, HMIS staff, and participating providers. Activities will leverage HUD and state CoC Planning and HMIS funding, Virginia Homeless Solutions Program resources, and partner/mainstream-system resources.

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

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

6. An individual or body responsible for overseeing implementation of specific strategies	Yes
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1C. Coordination and Engagement

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

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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?	57%

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)

Not applicable. The Fredericksburg Regional Continuum of Care (VA-514) is not designated by HUD as 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 Fredericksburg Regional CoC partners with behavioral health and healthcare providers to connect people experiencing homelessness to outpatient mental health and substance use disorder (SUD) treatment across Planning District 16. A key partner is the Rappahannock Area Community Services Board (RACSB), the regional public behavioral health authority serving the City of Fredericksburg and Caroline, King George, Spotsylvania, and Stafford counties. Effective July 1, 2026, RACSB is represented on the CoC Board, strengthening coordination between the homelessness response and regional behavioral health systems. RACSB provides a continuum of community-based mental health and SUD services, including outpatient treatment at varying levels of intensity, individual and group counseling and other psychosocial interventions, psychiatric services and medication management, substance use assessment and treatment, crisis intervention, and recovery-oriented services. Individuals requiring higher levels of care can be connected to appropriate crisis, stabilization, detoxification, residential, or other treatment resources. Crisis services also provide pathways for suicide prevention, assessment, stabilization, and connection to ongoing care. RACSB also operates permanent supportive housing (PSH) with funding from the Virginia Department of Behavioral Health and Developmental Services (DBHDS), further integrating permanent housing with behavioral health services and supports for individuals with behavioral health needs. CoC homeless assistance providers connect participants to RACSB and other community treatment providers through referrals, case management, care coordination, and assistance overcoming barriers to accessing care. Recovery supports complement clinical treatment through peer and recovery-oriented services and connections to community recovery resources. Through RACSB's participation in CoC governance, its operation of PSH, and coordination between homeless assistance and behavioral health providers, the CoC supports access to voluntary, person-centered mental health and SUD treatment, medication management, crisis and suicide prevention services, psychosocial interventions, and recovery supports while coordinating behavioral health care with housing assistance.

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 Fredericksburg Regional CoC provides access to peer recovery support through both homeless assistance projects and partnerships with the regional behavioral health system. Micah Ecumenical Ministries, a homeless assistance provider, integrates peer recovery specialists into its drop-in center and respite shelter. This allows people experiencing homelessness to engage with peer recovery support in familiar, low-barrier settings where they are already accessing shelter, basic needs, case management, and other services. Peer recovery specialists use lived experience to build relationships, support individualized recovery goals, provide recovery-focused education and encouragement, assist individuals in navigating mental health and substance use disorder treatment systems, and connect participants to treatment and community-based recovery resources. Embedding peer support within homeless services reduces barriers to engagement and creates opportunities for continued support as individuals pursue housing and recovery goals. The CoC also partners with the Rappahannock Area Community Services Board (RACSB), the public behavioral health authority serving all five CoC jurisdictions. RACSB incorporates peer recovery services within its behavioral health continuum and provides pathways to peer support, mental health and substance use treatment, crisis services, and other recovery resources. CoC providers further support recovery navigation through case management and care coordination, connecting participants to peer recovery specialists, behavioral health treatment, healthcare, benefits, transportation, and community-based recovery supports. Through Micah's embedded peer recovery specialists, RACSB's behavioral health and peer services, and the participation of both organizations in CoC Board, the CoC provides multiple pathways for people experiencing homelessness to access voluntary peer support and recovery navigation. These services complement housing assistance and clinical treatment while supporting individualized recovery and housing goals.

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 Fredericksburg Regional CoC identifies and connects individuals experiencing Serious Mental Illness (SMI) to services through ongoing assessment, case management, assertive engagement, and coordination with behavioral health providers. CoC case managers assess participants for mental health and behavioral health needs at intake and continue to assess needs throughout their participation in homeless assistance programs. Mental health needs and service connections are also discussed during regular CoC cross-provider case management meetings, allowing providers to identify emerging or changing needs, coordinate services, and address barriers to treatment and housing stability. Individuals with identified or suspected SMI are connected to qualified behavioral health professionals for clinical assessment and appropriate treatment. A key partner is the Rappahannock Area Community Services Board (RACSB), the public behavioral health authority serving all five CoC jurisdictions. RACSB provides behavioral health assessment, outpatient treatment, psychiatric and medication management services, crisis intervention, case management, and connections to more intensive community-based services based on individual needs. CoC providers use assertive engagement and care coordination to help individuals experiencing SMI access and remain connected to services. Micah Ecumenical Ministries engages people experiencing homelessness through street outreach, its low-barrier drop-in center, respite shelter, and housing programs. These settings provide opportunities to identify behavioral health needs, build trust, coordinate services, and re-engage individuals who may have difficulty accessing traditional service settings. For individuals requiring more intensive supports, providers coordinate connections to psychiatric services, medication management, crisis stabilization, intensive case management and care coordination, and other community-based behavioral health services. RACSB's DBHDS-funded permanent supportive housing further integrates behavioral health supports with long-term housing stability. Through ongoing assessment, cross-provider case conferencing, assertive outreach, behavioral health partnerships, and housing-based supports, the CoC works to connect individuals experiencing SMI to services necessary to achieve and maintain behavioral health and housing 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 the Spotsylvania Behavioral Health Docket, where CoC providers participate in the multidisciplinary process to connect individuals with housing and supportive services. RACSB provides therapy and peer support to docket participants. The CoC also helped develop the new Fredericksburg Therapeutic Docket, strengthening coordination among the courts, behavioral health providers, and the homelessness response system for individuals with behavioral health needs.

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 the Spotsylvania Behavioral Health Docket and Fredericksburg Therapeutic Docket to address the intersection of behavioral health needs, justice-system involvement, and housing instability. CoC providers participating in the docket process help identify participants who are experiencing or at risk of homelessness and connect them to appropriate housing resources, benefits, and supportive services. Providers coordinate with RACSB, court personnel, and other members of the multidisciplinary docket teams to align housing and service plans with participants' treatment and recovery goals. CoC providers support participants through housing navigation, case management, connection to mainstream benefits and community resources, and assistance addressing barriers that may jeopardize housing stability. RACSB provides behavioral health treatment and recovery supports, including therapy and peer support, while CoC providers focus on housing and other social determinants that can affect an individual's ability to successfully engage in treatment and remain stable in the community. The specialty docket structure provides ongoing judicial oversight and accountability. When treatment, evaluation, or other activities are required by the court, CoC providers coordinate with the participant and docket partners to help remove practical barriers to compliance, such as housing instability, transportation, access to benefits, and connections to services. Court orders can therefore reinforce engagement with treatment and other services, while the CoC works to ensure participants have the housing and community-based supports necessary to follow through successfully. This multidisciplinary approach allows the court, behavioral health providers, and homelessness response system to share information as permitted, identify emerging barriers, and coordinate interventions. By pairing judicial oversight and behavioral health treatment with housing assistance and supportive services, the partnership supports participants in achieving greater housing stability, reducing reliance on crisis systems, and moving toward greater independence.

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 RACSB, the regional public behavioral health authority and a key component of the local crisis system of care. RACSB provides 24/7 emergency behavioral health services, crisis assessment and intervention, crisis stabilization, and coordination with other crisis resources. RACSB also participates in the Marcus Alert system across all five CoC jurisdictions and connects individuals to the broader crisis continuum, including 988.

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.	0

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 Rappahannock Area Community Services Board (RACSB), the region's Community Mental Health Center and SAMHSA PATH provider. RACSB is represented on the CoC Board, operates permanent supportive housing, and coordinates with CoC providers to connect people experiencing homelessness and serious mental illness to outreach, treatment, case management, housing, and recovery supports.

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

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

(limit 500 characters)

The CoC does not currently have an existing or newly proposed CoC Program-funded project that operates sober housing.

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 with behavioral health, treatment, recovery, crisis, and specialty court partners to identify individuals experiencing or at risk of homelessness and connect them directly to appropriate housing resources. CoC providers assess housing and behavioral health needs at intake and throughout case management, and regular cross-provider case management meetings provide an additional mechanism to identify housing instability, coordinate services, and facilitate provider-to-provider referrals. RACSB, the region's Community Mental Health Center and PATH provider, coordinates with CoC providers to connect individuals receiving behavioral health, substance use, crisis, and PATH services to the homelessness response system when housing needs are identified. Rather than providing only contact information, partners facilitate warm hand-offs by connecting participants directly with CoC housing and homeless assistance providers, sharing relevant information with appropriate consent, coordinating appointments and referrals, and following up to support successful engagement. The CoC also coordinates with the Spotsylvania Behavioral Health Docket and Fredericksburg Therapeutic Docket so that individuals involved with specialty courts who have housing instability can be connected to housing navigation, case management, benefits, and supportive services. CoC outreach, shelter, housing, and peer-support providers similarly coordinate with behavioral health and recovery partners when participants need treatment or recovery services. When individuals are at imminent risk of homelessness, partners seek to intervene before shelter entry by connecting them to available prevention, diversion, mainstream benefits, natural supports, and other community resources. When homelessness cannot be prevented, individuals are connected to the CoC's Coordinated Entry system and appropriate housing interventions. This cross-system coordination helps maintain continuity of care, reduces gaps between treatment and housing services, and supports transitions to stable housing.

1C-2. Supportive Services Investment.

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$687,631
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.	\$439,454
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	64%
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.	\$245,644

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).

100%

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 Fredericksburg Regional CoC does not have a local metropolitan city or urban county ESG recipient within its geographic area. Therefore, the CoC consults with the Virginia Department of Housing and Community Development (DHCD), Virginia's state ESG recipient, regarding the planning and allocation of ESG resources serving the region. DHCD administers ESG funding through the Virginia Homeless Solutions Program (VHSP) funding structure. ESG resources are directed primarily to rapid re-housing, while state resources administered through VHSP support additional components of the homelessness response system. The CoC consults with DHCD through the state funding process, meetings and trainings, ongoing communication with DHCD staff, and participation in statewide homelessness planning activities. The CoC uses HMIS and system performance data, PIT/HIC data, its formal gaps analysis, provider and community input, and ongoing assessment of system capacity to establish regional funding priorities. These priorities inform the CoC's consultation with DHCD and its recommendations regarding how state and federal homelessness resources can best complement one another within the regional crisis response system. The CoC also coordinates locally to determine how ESG-funded rapid re-housing fits within the broader continuum of prevention, outreach, emergency shelter, Coordinated Entry, rapid re-housing, permanent housing, and supportive services. This helps ensure ESG resources complement rather than duplicate CoC Program and other federal, state, local, and private resources. The CoC will continue consulting with DHCD during future funding cycles by communicating regional needs and funding gaps, participating in DHCD planning and funding processes, reviewing system and project performance, and providing information regarding emerging needs and changes in local service capacity. This consultation supports alignment of ESG investments with the CoC's broader strategy for making homelessness rare, brief, and non-recurring.

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 Fredericksburg Regional CoC coordinates with emergency shelter (ES) providers through its Coordinated Entry system, CoC Helpline, regular case management meetings, and direct provider-to-provider coordination. ES providers identify the housing and service needs of individuals and families at intake and throughout their shelter stay and connect eligible households to the CoC's Coordinated Entry process for assessment, prioritization, referral, and housing assistance. ES providers participate in regular CoC case management meetings with housing and service providers to review housing needs, identify barriers, coordinate referrals, and support movement from shelter to permanent housing. Through this process, households can be connected to available CoC resources, including rapid re-housing, permanent supportive housing, housing navigation, mainstream benefits, behavioral health services, and other supportive services based on eligibility and need. CoC staff and providers maintain ongoing communication regarding program availability, eligibility requirements, referrals, and emerging needs. When a household is referred to a housing program, ES and housing providers coordinate the transition and share relevant information, with appropriate consent, to facilitate a warm hand-off and reduce duplication or gaps in services. The CoC also uses HMIS and Coordinated Entry data to monitor shelter utilization, length of time homeless, housing referrals, and system flow. Information from shelter providers is incorporated into CoC planning, gaps analysis, and funding decisions so that CoC resources can be targeted toward identified needs and barriers within the crisis response system. Through Coordinated Entry, case conferencing, data sharing, and direct provider coordination, the CoC works with emergency shelters to ensure individuals and families are connected to appropriate CoC housing assistance and can move from shelter to permanent housing as quickly as possible.

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)

As the CoC and HMIS Lead, GWRC regularly shares PIT, HIC, HMIS, and System Performance data with state and local governments to inform homelessness planning, funding, policy, and resource allocation. Data are shared consistent with the CoC's HMIS Privacy and Security Policies, applicable requirements, and participant privacy protections. Public and governmental reporting uses aggregate or de-identified data; personally identifiable information is not disclosed unless permitted by applicable privacy requirements and HMIS policies. Each year, the CoC produces a comprehensive PIT/HIC report, separate from HMIS reporting, summarizing the PIT Count and HIC. The report provides information on the extent and characteristics of homelessness and the capacity of the regional homelessness response system. It is distributed to state and local government partners and community stakeholders and posted on the CoC website for public review. The CoC also routinely submits HMIS data and performance information to the Virginia Department of Housing and Community Development (DHCD) as required for Virginia Homeless Solutions Program (VHSP) funding. These data allow the state to monitor program and system performance and inform administration of homelessness resources. The CoC and its providers also provide aggregate HMIS and program data to local governments as required for locally funded homelessness programs and to support local funding and planning decisions. HMIS and System Performance Measures are used to communicate trends and outcomes, including entries into homelessness, length of time homeless, exits to permanent housing, returns to homelessness, and other measures of system performance. Data are shared with the City of Fredericksburg and Caroline, King George, Spotsylvania, and Stafford counties through reports, presentations, funding requests, planning processes, and responses to requests for information. PIT, HIC, HMIS, and System Performance data also inform the CoC's gaps analysis, strategic priorities, funding recommendations, Coordinated Entry improvements, and evaluation of the homelessness response system. Findings are shared with the CoC Board, membership and committees, and community partners to support data-informed decisions regarding policies, programs, and resources.

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

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

(limit 2,500 characters)

The CoC uses data from law enforcement, corrections, public health, healthcare, and community partners alongside HMIS to improve individual care coordination and identify system-level needs. The CoC leads regular case conferencing with local law enforcement partners focused on individuals experiencing homelessness. During these meetings, law enforcement partners share relevant reports and information regarding interactions with individuals experiencing homelessness. This information is considered alongside HMIS and provider information to identify individuals with frequent system interactions, better understand current needs and risks, coordinate outreach and services, and develop appropriate housing and service responses. The CoC also leads case conferencing with local jails. Jail records are accessed as part of this process to support coordinated case discussions and identify individuals whose incarceration, behavioral health needs, and housing instability intersect. CoC and corrections partners use this information to coordinate services, identify housing needs and barriers, and improve connections to housing and community-based supports upon release, with the goal of reducing exits from institutions into homelessness. The CoC also works with healthcare and public health partners to understand broader community health needs. The CoC is an active partner in the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) processes with the Rappahannock Area Health District (RAHD) and Mary Washington Healthcare (MWHC). These processes bring together health and community data to identify regional health needs, establish priorities, and develop collaborative strategies. CoC participation ensures that homelessness and housing instability are incorporated into broader community health planning and allows health-related data and trends to inform homelessness response strategies. These sources are supplemented by PIT/HIC data, Coordinated Entry information, provider data, community surveys, and stakeholder feedback. Together with HMIS, these data help the CoC identify individuals with cross-system needs, improve referrals and care coordination, identify service gaps, and strengthen coordination among homelessness, healthcare, behavioral health, public safety, and corrections systems. Information is shared and used consistent with applicable privacy and confidentiality requirements.

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 Works, the Commonwealth's workforce development agency. A Virginia Works representative serves on the CoC Funding Committee and reviewed all project applications considered for inclusion in the FY26 CoC Program application. Virginia Works also actively participates in the CoC Veteran Working Group, supporting coordination of employment, housing, and services for veterans experiencing homelessness.

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

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

(limit 2,500 characters)

The CoC's street outreach system works closely with law enforcement, first responders, local government, behavioral health, and community partners to increase positive interactions with individuals experiencing unsheltered homelessness and connect them to housing and services. The CoC has formal, signed MOUs supporting coordination with law enforcement in three of its five jurisdictions, in addition to ongoing collaboration with law enforcement throughout the region. The CoC leads regular case conferencing with law enforcement focused on individuals experiencing homelessness. Law enforcement partners share relevant information regarding contacts and interactions, while street outreach and CoC providers contribute information regarding engagement, housing needs, service connections, and barriers. This helps partners identify individuals with frequent cross-system interactions, coordinate outreach, and re-engage individuals who may be difficult to reach. One example is a coordinated street outreach response developed in the City of Fredericksburg following concerns raised by downtown businesses regarding interactions with individuals experiencing homelessness. The CoC partnered with the City of Fredericksburg, Fredericksburg Police Department, RACSB, and Fredericksburg Main Street to develop a service-oriented response. The City funds a dedicated RACSB street outreach worker who is dispatched to homelessness-related calls received by the Police Department. Rather than relying solely on a law-enforcement response, the outreach worker can engage the individual, assess needs, build rapport, and connect the person to behavioral health services, Coordinated Entry, housing resources, and other community supports. The partnership also provides businesses and community partners with an appropriate pathway for connecting individuals to assistance. Micah Ecumenical Ministries also conducts street outreach throughout the region and coordinates with law enforcement and community partners to engage individuals living in unsheltered locations and connect them to housing and services. Through formal MOUs, case conferencing, coordinated response, direct referrals, and community partnerships, the CoC works to increase positive interactions, strengthen engagement with CoC services, and create pathways from unsheltered homelessness to permanent housing.

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)

Family and support-network reunification is incorporated into the CoC's systemwide diversion and housing problem-solving process. Every individual or family seeking assistance through the homeless response system receives diversion/problem-solving to explore safe alternatives to entering or remaining in homelessness. This includes identifying relatives, friends, and other natural supports who may be able to provide housing or other assistance. When a safe and appropriate family or support-network option is identified, CoC providers actively work to facilitate reunification. Assistance may include mediation between the participant and family or support person, case management, coordination of the reunification plan, and payment of travel costs when transportation is necessary to reconnect the participant with housing or support. Providers may also coordinate services and resources in another geographic area to help ensure the transition is successful and sustainable. The CoC also partners closely with local Departments of Social Services (DSS) to connect households to benefits, family services, and other mainstream resources that can support stabilization. Four of the five DSS agencies within the CoC geography are actively involved in CoC governance and planning: two are represented on the CoC Board and two additional DSS agencies participate on the CoC Funding Committee. For individuals already participating in CoC-funded housing, case managers continue to identify and strengthen family and natural support networks as part of individualized housing stability planning. Reunification is voluntary and participant-driven and is pursued only when the arrangement is safe, appropriate, and consistent with the participant's needs and goals. By incorporating reunification into diversion and ongoing case management, the CoC uses family and natural supports as an important resource for preventing homelessness, resolving homelessness when it occurs, and strengthening long-term housing stability.

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 actively cooperates with law enforcement, first responders, local governments, behavioral health providers, and street outreach partners to address the intersection of homelessness, public safety, and access to services. The CoC does not interfere with or impede lawful public-safety activities; instead, it provides pathways for first responders to connect individuals experiencing homelessness to housing, behavioral health, substance use, healthcare, and other services. Law enforcement is integrated into CoC governance and operations. The Fredericksburg City Police Chief serves on the CoC Board, and the CoC has signed coordination MOUs with law enforcement in three of its five jurisdictions. The CoC also leads regular case conferencing with law enforcement to coordinate outreach, service connections, and responses for individuals experiencing homelessness. Street outreach and behavioral health partners provide first responders with alternatives to relying solely on a law-enforcement response. In Fredericksburg, the CoC partnered with the City, Police Department, RACSB, and Fredericksburg Main Street to establish a coordinated response that includes a City-funded RACSB street outreach worker who responds to homelessness-related police calls. Spotsylvania's Sheriff's Office Behavioral Health Unit and Co-Response Program coordinate referrals and outreach with the CoC. Stafford's Sheriff's Office works with Micah Ministries, RACSB, Stafford RISE, and its Co-Responder Team to connect individuals to resources. Micah provides regional street outreach and receives approximately 2–3 law-enforcement calls per week requesting assistance connecting individuals to services. The CoC also coordinates with law enforcement during the annual PIT Count and when encampments are identified. Law enforcement helps identify locations and individuals needing outreach, while CoC partners provide engagement, Coordinated Entry, housing navigation, behavioral health connections, and other services. When encampments must be addressed, outreach partners assist affected individuals while respecting the separate responsibilities and legal authority of law enforcement and local government. Through Board representation, MOUs, case conferencing, Co-Response, street outreach, PIT collaboration, encampment response, and direct referrals, the CoC assists first responders and supports, rather than impedes, lawful local public-safety efforts.

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

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

(limit 2,500 characters)

The CoC leverages local practices that pair encampment response with outreach and services. Spotsylvania Sheriff's Behavioral Health Unit (BHU) and Co-Response Program refer unhoused individuals to the CoC. Stafford Sheriff's Office tracks encampments through ZeeMaps and its records system and coordinates outreach with Micah Ministries and RACSB. In Fredericksburg, a City-funded RACSB street outreach worker responds to law-enforcement referrals. Micah provides regional street outreach and receives approximately 2–3 law-enforcement calls weekly. These practices show measurable results. When Spotsylvania BHU increased its involvement with the unhoused population in 2024, the County had 11 known active encampments with multiple individuals in each. In 2026, three remain, with none currently known on public property. Since spring 2025, BHU has referred approximately 33 contacts to the CoC. Stafford reports three encampments removed in 2026 while services continued for those involved and two individuals assisted from vehicle homelessness into more stable housing. Fredericksburg does not maintain comparable counts; partners report few established campsites, with individuals more often sleeping in parks or other public spaces. The CoC will leverage these practices through direct law-enforcement referrals, Co-Response, case conferencing, and outreach before, during, and after encampment responses. Providers connect individuals to Coordinated Entry, shelter/housing, behavioral health and substance use services, healthcare, benefits, and other resources. During an April 2026 Stafford encampment response, partners connected the individual to temporary hotel/motel accommodations. Restrictive factors include limited outreach staffing and shelter/housing availability, difficulty maintaining engagement following displacement, and obtaining property-owner participation for camps on private property. Law enforcement reports that outreach and Co-Response staff can spend more time building rapport and navigating services than patrol personnel. The CoC mitigates these barriers through repeated outreach, coordinated referrals, and case conferencing. Building on Stafford's tracking practice, the CoC will work toward consistent regional tracking of encampments, outreach contacts, referrals, and outcomes.

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 continues to experience unsheltered homelessness, although the prevalence and form of encampments vary across the region and is relatively small overall. The 2026 PIT Count identified 12 individuals experiencing unsheltered homelessness across the CoC's five jurisdictions. The CoC does not currently maintain a single standardized regional encampment count; additional information is gathered through street outreach, law enforcement, PIT Count activities, Coordinated Entry, and local tracking practices. Spotsylvania County has documented a substantial reduction in known encampments. When the Sheriff's Office Behavioral Health Unit (BHU) increased its involvement with the unhoused population in 2024, it identified 11 active encampments with multiple individuals in each. As of 2026, three known active encampments remain, with no known encampments currently located on public property. Since spring 2025, BHU has referred approximately 33 contacts to the CoC for outreach and connection to services. Stafford County tracks interactions with unhoused individuals and encampments through ZeeMaps and its records management system. Stafford reports three encampments removed in 2026 while outreach and service connections continued for those involved. Stafford has also assisted two individuals living long-term in vehicles to transition to more stable housing. Fredericksburg does not maintain a comparable quantitative encampment count. Local partners report few established campsites within the City, with unsheltered homelessness more commonly involving individuals sleeping in parks or other public spaces. Regional street outreach provider, Micah Ministries, also reports relatively few established campsites in Fredericksburg and regularly coordinates with law enforcement in Fredericksburg, Stafford, and Spotsylvania when individuals or encampments are identified. Micah receives approximately 2–3 law-enforcement calls per week related to individuals needing outreach and service connections. Overall, available PIT, law-enforcement, and outreach information indicates that large established encampments are not currently prevalent across the CoC, but unsheltered homelessness continues in smaller camps, vehicles, parks, and other public or private locations. The CoC continues coordinating with local partners to identify these locations and connect individuals to housing and 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)

The CoC uses established partnerships among street outreach, law enforcement, first responders, and behavioral health providers to connect individuals using illicit drugs in public to appropriate treatment and services while respecting law enforcement's public-safety role. CoC-led case conferencing, Co-Response programs, and direct referral relationships allow law enforcement to connect individuals experiencing homelessness with outreach and behavioral health professionals. A beneficial policy is Virginia's overdose response law, which provides specified protections from arrest or prosecution for certain offenses when an individual seeks emergency medical assistance for an overdose. Locally, RACSB provides substance use assessment and treatment, Same Day Access, recovery services, and a Mobile Recovery Unit that brings medication for opioid use disorder into the community. RACSB also partners with law enforcement and CoC providers, allowing individuals encountered in public spaces to be connected to behavioral health and substance use services. The CoC leverages these practices by maintaining direct referral pathways among law enforcement, Co-Response teams, street outreach, RACSB, and other providers. When outreach or first responders encounter an individual using illicit drugs in public, immediate health and safety needs can be addressed and the individual connected to appropriate treatment, recovery, healthcare, housing, and other services. Micah Ministries facilitates access to inpatient and outpatient substance use treatment when individuals are willing to engage and uses continued outreach and relationship-building to support treatment engagement. Barriers include limited treatment and outreach capacity, individuals not being ready to enter treatment when first contacted, difficulty maintaining contact with individuals experiencing unsheltered homelessness, and competing behavioral health and housing needs. The CoC mitigates these barriers through repeated engagement, peer and outreach relationships, Co-Response, case conferencing, and coordination of housing and behavioral health services rather than relying on a single referral.

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)

Overdose and illicit drug use remain concerns within the CoC; however, no regional data source currently identifies the number of overdoses or incidents of illicit drug use occurring specifically in public spaces. The CoC, therefore, uses available public-health data together with information from law enforcement, first responders, behavioral health providers, and street outreach to understand local conditions. The Rappahannock Area Community Health Improvement Plan, using Virginia Department of Health data, reports all-drug overdose death rates per 100,000 population of 48.6 in Caroline, 20.3 in Fredericksburg, 21.9 in King George, 26.0 in Spotsylvania, and 20.4 in Stafford. All-drug overdose hospitalization rates per 100,000 were 256.0 in Caroline, 271.3 in Fredericksburg, 189.9 in King George, 226.8 in Spotsylvania, and 151.8 in Stafford. These data demonstrate that overdose continues to affect every jurisdiction in the CoC.

These figures are community-level measures and do not indicate where the overdose occurred or whether illicit drug use occurred in a public space. The CoC is not aware of a reliable regional data source that isolates overdoses or illicit drug use occurring specifically in public spaces and therefore does not infer the prevalence of public drug use from these figures.

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)

The CoC utilizes Virginia's Emergency Custody Order (ECO) and Temporary Detention Order (TDO) processes when an individual experiencing homelessness presents a danger to self or others or is unable to protect themselves from serious harm due to mental illness. Virginia law establishes specific criteria for involuntary intervention, including a substantial likelihood of serious physical harm to self or others or serious harm resulting from an inability to protect oneself or provide for basic needs. RACSB, the region's public behavioral health authority, is a key CoC and crisis-system partner. CoC providers, street outreach, law enforcement, and first responders coordinate with RACSB when an individual appears to require crisis assessment or intervention. Outreach providers are familiar with the ECO process and can provide relevant information regarding observed behaviors and circumstances, while qualified behavioral health professionals and the legal system determine whether statutory criteria for involuntary intervention are met. A beneficial local practice is the region's increasing use of behavioral-health/law-enforcement Co-Response. Spotsylvania and Stafford have Co-Response partnerships, and Fredericksburg has a dedicated RACSB street outreach worker who responds to homelessness-related law-enforcement calls. These relationships allow behavioral health professionals to become involved earlier and provide assessment and connections to crisis or voluntary services when involuntary intervention is not appropriate. A limitation is that Virginia law establishes a specific threshold for involuntary intervention; homelessness, substance use, or concerning behavior alone does not establish eligibility for an ECO/TDO. The CoC mitigates this limitation through repeated outreach, case conferencing, Co-Response, crisis-service referrals, and coordination with RACSB so individuals who do not meet involuntary-treatment criteria can still be connected to voluntary behavioral health, substance use, healthcare, housing, and supportive services.

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)

The CoC cooperates with law enforcement to support compliance with SORNA and Virginia's Sex Offender and Crimes Against Minors Registry requirements. Virginia law requires individuals subject to registration who do not have a legal residence to designate a location that can be located with reasonable specificity where they reside or habitually locate themselves. Local law enforcement collects required registration information and forwards it to Virginia State Police. A beneficial local practice is coordination among law enforcement and homeless-service providers regarding individuals experiencing homelessness who have registration requirements. Micah Ministries allows its office to serve as a mailing/contact address for registry-related paperwork and, when requested, assists with verification of an individual's location. CoC-led case conferencing and established law-enforcement partnerships provide additional mechanisms for appropriate information sharing, consistent with applicable law and confidentiality requirements. Homelessness can complicate compliance because individuals may lack a fixed address, change sleeping locations, or be difficult to locate. Registration requirements may also create additional barriers when identifying appropriate housing options. The CoC mitigates these challenges through continued outreach, assistance maintaining reliable contact, housing navigation, and direct coordination with law enforcement.

1C-11. Outreach Strategy.

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

(limit 2,500 characters)

The CoC's strategy combines street outreach, the CoC Helpline/Coordinated Entry, HMIS, community referrals, law-enforcement and first-responder partnerships, behavioral health outreach, and ongoing case coordination. Micah Ministries conducts regional street outreach and identifies individuals through direct outreach, community and law-enforcement requests, "inreach" through its programs and community networks, and individuals known to be living outside who are not accessing services. Once identified, individuals are enrolled in outreach, maintained through ongoing contact by staff and volunteers, and prioritized based on vulnerability. The prioritization process includes everyone known to be actively experiencing homelessness. Outreach is relationship-based and includes repeated engagement when individuals are not initially ready to accept services. RACSB provides behavioral health-focused outreach, including its SAMHSA PATH program for individuals experiencing homelessness with serious mental illness. PATH provides outreach, engagement, case management, and connections to behavioral health, housing, benefits, and other services. RACSB also operates the City-funded Fredericksburg street outreach position that responds to homelessness-related law-enforcement referrals. Micah street outreach/case management, RACSB street outreach/case management, and RACSB PATH are HMIS-participating projects. Outreach contacts, services, and case management are documented in HMIS, supporting continuity of engagement, provider coordination, identification of needs, and connections to Coordinated Entry and housing. Additional outreach pathways include Spotsylvania's Sheriff's Office Behavioral Health Unit and Co-Response Program and Stafford's Sheriff's Office, Co-Responder Team, Stafford RISE, and other partners. Referrals also originate from shelters, DSS, healthcare providers, schools, faith communities, and other community partners. The CoC Helpline/Coordinated Entry provides centralized access for individuals and families, including diversion/problem-solving and connections to shelter, prevention, housing, and services. The annual PIT Count and regular cross-provider case conferencing supplement year-round outreach and help identify individuals who are difficult to locate or engage.

1C-12.	Collaboration Related to Children and Youth—Written Agreements with Early Childhood Services Providers.	
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Select 'Yes' or 'No' in the chart below to indicate whether your CoC or HUD-funded projects in the CoC have written agreements with the listed providers of educational supports and services for children ages 0-5:

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

9.		
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1C-12a.	Collaboration Related to Children and Youth—Formal Partnerships with Schools and Youth Education Providers.	
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Select 'Yes' or 'No' in the chart below to indicate the youth education providers your CoC has a formal partnership with:

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

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

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

(limit 2,500 characters)

The CoC does not currently have a formal written CoC policy or procedure specifically addressing notification of educational-service eligibility. However, the CoC has an established practice of coordinating with the McKinney-Vento liaisons serving the City of Fredericksburg and Caroline, King George, Spotsylvania, and Stafford Counties to connect children, youth, and families experiencing homelessness with educational resources. Homeless-service providers identify households with school-age children and youth and inform families of available McKinney-Vento educational rights and resources. Providers maintain information for local school division McKinney-Vento liaisons and connect families with the appropriate liaison when a child or youth experiencing homelessness is identified. Providers and liaison staff coordinate as needed to address educational needs throughout the household's involvement with homeless services. The CoC recognizes that, while these practices are established through provider and school-system partnerships, they are not currently incorporated into a formal written CoC policy or procedure. Formalizing the existing notification and referral process within the CoC's written policies and procedures has been identified as an area for improvement.

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

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

(limit 2,500 characters)

The CoC coordinates with local Departments of Social Services (DSS), housing partners, and homeless-service providers to assist youth transitioning from foster care and other child welfare systems and to reduce the risk that youth exit public systems of care into homelessness. The CoC maintains relationships with DSS agencies serving the City of Fredericksburg and Caroline, King George, Spotsylvania, and Stafford Counties. DSS and child welfare partners can connect youth and young adults who are experiencing or at risk of homelessness with the CoC's Coordinated Entry system and other housing and supportive-service resources. CoC providers also coordinate with DSS when individuals entering the homeless response system have current or recent involvement with foster care or child welfare services. The region has also coordinated around Foster Youth to Independence (FYI) vouchers, which provide an important housing pathway for eligible youth with a history of foster care involvement. Coordination among child welfare, housing, and homeless-service partners supports identification of potentially eligible youth, referral to the appropriate housing resource, and connection to supportive services. The CoC's broader coordination structure—including Coordinated Entry, case conferencing, and relationships among DSS, housing, behavioral health, and community-service providers—allows partners to address housing instability and other service needs as youth transition from public systems of care. The CoC will continue strengthening coordination with child welfare partners to identify youth approaching or exiting foster care who are at risk of homelessness, connect them to available housing resources before a housing crisis occurs, and improve transitions from public systems of care into stable housing.

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

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

(limit 2,500 characters)

There are currently no Runaway and Homeless Youth (RHY)-funded providers operating within the Fredericksburg Regional CoC's geographic area.

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)

Loisann's Hope House – Family Rapid Rehousing. The project provides rapid rehousing specifically for families with children experiencing homelessness within the Fredericksburg Regional CoC.

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)

Loisann's Hope House RRH provides housing-focused case management and supportive services to families with children experiencing homelessness, with an emphasis on increasing household income and building the financial stability necessary to sustain rent after temporary rental assistance ends. Case managers work individually with participating families to identify barriers to employment and income and develop goals that support long-term housing stability. Families receive assistance related to employment, income growth, budgeting and financial management, transportation, childcare, and other needs that may affect a parent's ability to obtain or maintain employment. When additional employment, education, or training resources are needed, families are connected to appropriate community resources and services. These supports are coordinated with the project's housing search, placement, and temporary financial assistance so that employment and income goals are directly connected to each household's ability to assume its housing costs. By addressing barriers such as childcare and transportation while supporting employment and income growth, Loisann's Hope House helps families increase their capacity to maintain housing and pay rent independently as Rapid Re-Housing assistance decreases.

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)

Loisann's Hope House RRH leverages mainstream family service systems as part of its housing-focused case management for families with children experiencing homelessness. Case managers work with participating families to identify benefits and resources for which they may be eligible and assist families with accessing and applying for mainstream programs, including Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Medicaid/FAMIS, childcare assistance, and other available family supports. These benefits can increase household resources and reduce expenses that might otherwise compete with rent and other housing costs. The project also operates within a broader CoC system that has intentionally invested in mainstream benefit access. GWRC partners with Fredericksburg Christian Health Center (FCHC) to provide a Community Benefit Navigation program supported through separate hospital foundation funding. Benefit navigators assist community members with determining eligibility, completing applications, gathering required documentation, and navigating enrollment for Medicaid, FAMIS, SNAP, TANF, and other mainstream benefits. Families participating in Rapid Re-Housing can be connected to this resource when additional or specialized benefits-navigation assistance is needed. These resources complement Rapid Re-Housing assistance rather than relying on housing funds to meet all of a family's financial and supportive-service needs. By combining rental assistance and housing-focused case management with access to mainstream income, nutrition, healthcare, childcare, and family-support programs, Loisann's Hope House helps families maximize available resources, address financial barriers to housing stability, and increase their ability to sustain rent after temporary Rapid Re-Housing assistance ends

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)

Loisann's Hope House RRH combines rental assistance and housing-focused case management with services that address the broader needs of families with children. Each family receives individualized case management that identifies barriers to housing stability and connects parents and children to childcare, parenting resources, healthcare, and educational supports based on the needs of the household. Case managers assist families in identifying and accessing childcare resources so that childcare needs do not prevent parents from obtaining or maintaining employment, participating in education or training, or meeting other housing-stability goals. Families are also connected with parenting resources and other supports that strengthen family stability and address the needs of parents and children while they transition from homelessness to permanent housing. For healthcare needs, families are connected to community healthcare resources, including Fredericksburg Christian Health Center, which provides access to primary healthcare and benefit-navigation services. Case management also assists families in connecting to appropriate pregnancy-related, maternal, and child healthcare resources and obtaining healthcare coverage, including Medicaid and FAMIS, when eligible. Educational needs are incorporated into case management for both children and parents. Families are assisted with connections to schools and educational resources to support continuity in children's education during and after homelessness. Parents can also be connected to education, employment, and training resources that support increased income and long-term housing stability. By coordinating these supports with RRH rental assistance and individualized housing stability planning, Loisann's Hope House addresses both the immediate need for permanent housing and the childcare, parenting, healthcare, and educational needs that can affect a family's ability to maintain that 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 Fredericksburg Regional Continuum of Care maintains active partnerships with the Hunter Holmes McGuire VA Medical Center/VA Richmond Health Care System and Volunteers of America Chesapeake & Carolinas (VOACC) through its Supportive Services for Veteran Families (SSVF) program. Both partners participate in Veteran-focused coordination with the CoC, including case conferencing and the Veteran By-Name List, to connect Veterans to housing and supportive services.

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 Empowerhouse, the region's victim service provider serving survivors of domestic violence and their children. Empowerhouse participates in the CoC and coordinates with community partners to provide confidential shelter, housing assistance, advocacy, safety planning, and supportive services for survivors fleeing domestic violence, dating violence, sexual assault, and stalking.

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

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

(limit 500 characters)

The CoC partners with RACSB and FailSafe-ERA to prevent homelessness among people transitioning from incarceration. RACSB provides behavioral health and substance use services within the regional jail and supports connections to community-based services upon release. FailSafe-ERA provides reentry support and helps individuals connect with housing and other resources needed for a successful transition back into the community.

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

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

(limit 500 characters)

The CoC partners with Mary Washington Healthcare, Fredericksburg Christian Health Center, and the Rappahannock Area Health District to address the needs of people experiencing homelessness with significant medical needs. Partners coordinate referrals and access to hospital, primary care, public health, chronic disease management, medications, benefits navigation, and other supportive services to improve continuity of care and reduce reliance on emergency healthcare.

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

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

(limit 500 characters)

The CoC partners with Healthy Generations Area Agency on Aging and the Departments of Social Services in all five jurisdictions to connect older adults experiencing homelessness with aging services, benefits, care coordination, and other supports. The CoC also participates in the City of Fredericksburg's Adult Protective Services Collaborative, strengthening coordination for vulnerable older adults experiencing homelessness, abuse, neglect, or self-neglect.

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)

Micah Ecumenical Ministries' HUD Continuum of Care Permanent Supportive Housing (PSH) Program prioritizes individuals experiencing chronic homelessness for permanent supportive housing through the CoC's Coordinated Entry and prioritization process.

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)

Micah Ecumenical Ministries' HUD CoC-Funded Permanent Supportive Housing program provides on-site behavioral healthcare through integrated partnerships with Fredericksburg Christian Health Center (FCHC) and Rappahannock Area Community Services Board (RACSB). Through Micah's HealthBridge program, FCHC provides healthcare services on-site at Micah, allowing individuals experiencing homelessness and PSH participants to access care in a familiar setting where they are already engaged with housing and supportive services. Micah also co-locates RACSB's Projects for Assistance in Transition from Homelessness (PATH) worker on-site. The PATH worker provides behavioral health outreach and engagement and helps individuals experiencing homelessness connect with mental health, substance use, and other behavioral health services. Co-location facilitates direct communication and coordination among housing, healthcare, and behavioral health providers and allows needs to be addressed alongside participants' housing goals. This integrated model is particularly important for individuals experiencing chronic homelessness, who may have significant behavioral and physical health needs and face barriers to accessing traditional healthcare settings. Bringing FCHC and RACSB services into Micah's service environment reduces barriers to care, creates opportunities for earlier engagement, and supports continuity between housing and healthcare services. These partnerships allow Micah's PSH program to address behavioral health needs as part of a broader housing stability plan, supporting treatment engagement, recovery, and long-term housing retention.

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)

Micah Ecumenical Ministries' CoC-Funded PSH program assesses participants on an ongoing basis to determine whether their health, behavioral health, functional, or safety needs require a higher level of care than can appropriately be provided within permanent supportive housing. Through regular case management and coordination with healthcare and behavioral health partners, staff monitor changes in participants' needs and functioning.

Micah's co-located partnerships with Fredericksburg Christian Health Center through HealthBridge and Rappahannock Area Community Services Board (RACSB), including its PATH worker, provide additional opportunities to identify changes in physical or behavioral health needs. When a participant demonstrates needs that may exceed the level of support available through PSH, Micah coordinates with appropriate healthcare, behavioral health, and community-service partners to assess the need for a higher level of care and facilitate connections to services such as residential treatment, assisted living, or other appropriate care settings.

The goal is to identify changing needs early and coordinate an appropriate transition when necessary, while maintaining housing stability and continuity of care throughout the process.

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)

Micah Ecumenical Ministries' HUD Continuum of Care Permanent Supportive Housing program regularly assesses participants' housing stability and readiness to transition to unsubsidized or other permanent housing when appropriate. Through ongoing case management and individualized housing stability planning, staff review each participant's circumstances, including income and benefits, ability to meet housing expenses, connection to healthcare and behavioral health services, independent living skills, housing stability, and the level of supportive services needed to maintain housing. When a participant demonstrates increased stability and may no longer require the level of rental assistance or supportive services provided through PSH, staff work with the participant to explore appropriate move-on opportunities. Options may include unsubsidized rental housing or other permanent housing resources that better match the participant's current needs and financial circumstances. Move-on planning is individualized and participant-centered and considers whether the participant has sufficient income or rental assistance, appropriate community-based supports, and a sustainable housing plan before transitioning from PSH. Staff assist with identifying housing options, addressing barriers to transition, and coordinating connections to benefits and community services needed to maintain stability after leaving the program. This process allows PSH resources to remain available for individuals with the greatest ongoing need while supporting participants who are ready for greater housing independence.

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

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

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

1D-1.	Project Review and Ranking Process Your CoC Used in Its Local Competition. We use the response to this question along with the required attachment as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.	
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You must upload the Local Competition Scoring Tool attachment to the 4A. Attachments Screen.

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

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

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

1D-2a.	Web Posting of CoC-Approved Consolidated Application Before the CoC Program Competition Application Submission Deadline.	
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	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website—which included: 1. the CoC Application, and 2. Project Priority Listings.	09/28/2026
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1D-2b.	Notification to Community Members and Key Stakeholders by Email that the CoC-Approved Consolidated Application is Posted on the Website.	
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	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/28/2026
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1D-2c.	Local Competition Selection Results for All Projects.	
	You must upload the Local Competition Selection Results attachment to the 4A. Attachments Screen.	

	Does your attachment include: 1. Project Names, 2. Project Scores, 3. Project Rank, 4. Project Status—Accepted, Rejected, Reduced Reallocated, Fully Reallocated, 5. Amount Requested from HUD, and 6. Reallocated Funds +/-.	Yes
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1D-2d.	Projects Rejected/Reduced—Notification Outside of e-snaps.	
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1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	08/10/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

1D-2e.	Projects Accepted—Notification Outside of e-snaps.	
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	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	08/10/2026
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1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
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	Describe:
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

The Fredericksburg Regional CoC uses a competitive, performance-based process to review existing CoC Program-funded projects and identify potential candidates for reallocation. All renewal projects are reviewed through the local competition using the CoC's adopted scoring and ranking process. The review considers objective project and system performance criteria, including project outcomes, expenditure and utilization of grant funds, data quality, compliance, returns to homelessness, employment income, supportive service participation, and continued community need. Projects demonstrating lower performance, significant unspent funds, compliance concerns, or reduced need may be considered for partial or full reallocation.

During the FY 2026 local competition, the CoC reviewed all renewal projects through this process. The review did not identify any renewal projects as low performing or less needed to the extent that involuntary reallocation was warranted. However, two renewal project applicants voluntarily reallocated funding in response to the significant changes in the FY 2026 competition and HUD priorities. The applicants and CoC determined that voluntarily making funds available for reallocation would strengthen the CoC's overall competitiveness and allow resources to be redirected toward eligible new project activities more closely aligned with the FY 2026 funding opportunity.

The CoC therefore reallocated funding from two existing renewal projects during the FY 2026 local competition. These reallocations were voluntary and strategic rather than the result of a determination that either project was low performing. The Funding Committee considered the reallocated funds as part of the local competition and developed funding and ranking recommendations consistent with the CoC's established review process and current community needs.

Because the performance review did not identify additional projects whose performance or continued need warranted reallocation, the CoC did not involuntarily reallocate funds from other renewal projects. This approach allowed the CoC to preserve effective existing projects while also using voluntary reallocation to respond to the FY 2026 competition and strengthen the overall project portfolio.

1D-3a.	Reallocation Between FY 2021 and FY 2026.	
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	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2021 and FY 2026?	Yes
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2A. Homeless Management Information System (HMIS) and System Performance

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

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

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

	Enter the name of the HMIS Vendor your CoC is currently using.(limit 75 characters)	Wellsky
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2A-2.	HMIS Implementation Coverage Area.	
	Not Scored–For Information Only	

	Select from dropdown menu your CoC's HMIS coverage area.	Multiple CoCs
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2A-3.	PIT Count–Methodology Change.	
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	Describe:
1.	any changes your CoC made to your unsheltered PIT count implementation, including methodology or data quality changes between 2025 and 2026, if applicable, and
2.	how the changes affected your CoC's PIT count results.

(limit 2,500 characters)

he Fredericksburg Regional CoC did not make significant planned changes to its unsheltered PIT Count methodology between 2025 and 2026. However, implementation of the 2026 PIT Count was significantly affected by severe winter weather. The count occurred during the January 2026 ice storm in Virginia, which created unusually hazardous conditions during the unsheltered count.

The severe weather may have affected the 2026 PIT Count results in several ways. Individuals who would ordinarily have been unsheltered may have sought temporary shelter with family or friends, in emergency warming locations, or in other places not typically used for habitation. Ice and hazardous travel conditions also affected the ability to access some locations where people experiencing unsheltered homelessness may have been staying.

As a result, the CoC recognizes the severe weather as an important limitation when comparing the 2026 unsheltered PIT Count with the 2025 count. While the CoC continued to implement its established PIT methodology, the weather conditions may have resulted in fewer individuals being observed or contacted during the count and may have contributed to differences between the 2025 and 2026 results.

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)

Between January 1, 2025 - December 31, 2025, the Fredericksburg Regional CoC worked with local governments, law enforcement, first responders, and homeless service providers to address unsheltered homelessness and reduce the number of people residing in encampments. The CoC's role focused on coordinating outreach, connecting individuals with available housing and services, and improving communication among the agencies encountering people experiencing unsheltered homelessness. The CoC supported ongoing street outreach and Coordinated Entry efforts to identify individuals living in encampments and other unsheltered locations, assess their housing and service needs, and connect them to available shelter, housing, behavioral health, healthcare, and other community resources. Individuals identified through outreach were incorporated into the CoC's broader Coordinated Entry and case-conferencing processes to support housing connections and reduce prolonged periods of unsheltered homelessness. The CoC also strengthened coordination with local law enforcement and government partners through regular collaborative meetings focused on homelessness and public safety. These meetings provide a forum for law enforcement, homeless service providers, and the CoC to share information about emerging encampments and individuals needing assistance, coordinate outreach and service responses, and clarify the respective roles of public safety and homeless service organizations. In July 2025, The City of Fredericksburg also directed funding toward a full time street outreach worker. Though the CoC does not conduct encampment enforcement or cleanup activities, when local jurisdictions address encampments, the CoC's role is to facilitate coordination with homeless service providers so that individuals can be engaged and offered connections to appropriate housing and services. This approach allows the CoC to maintain its service-focused role while working collaboratively with jurisdictions addressing encampments and public-space concerns.

2A-4a.	Reduce Encampments—Number of Encampments.	
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1. Enter the estimated number of encampments in the beginning of your evaluation period.	15
2. Enter the reduction in the number of encampments during your evaluation period.	5

2A-4b.	Reduce Encampments—Number of People in Encampments.	
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1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	45
2. Enter the reduction in the number of people in encampments during your evaluation period.	15

2A-4c.	Reduce Encampments—Plans to Reduce Encampments.
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If there has been no reduction in encampments or persons in encampments in your CoC, describe the plans your CoC has to participate in efforts to reduce these numbers.

(limit 2,500 characters)

Not Applicable.

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)

The Fredericksburg Regional CoC uses HMIS data collected through the Coordinated Entry System (CES) to identify factors associated with households experiencing homelessness for the first time and to target prevention and diversion strategies. Local HMIS analysis has identified institutions, hotels, and doubled-up situations as common living situations immediately preceding entry into emergency shelter. The CoC uses this information to focus prevention efforts on households exiting institutions or temporarily staying in hotels or with family or friends who are at imminent risk of homelessness. CES screening also considers prior experiences of homelessness when assessing household circumstances and appropriate interventions. All households accessing CES receive a diversion conversation focused on identifying a safe alternative to entering homelessness. Households are referred to emergency shelter when diversion is not possible and emergency housing is needed. Households in temporary housing situations, including those doubled-up, exiting institutions, or staying in hotels, who are at imminent risk of homelessness are assessed for available homelessness prevention resources. Eligible households work with providers to stabilize their current housing or identify alternative permanent housing before entering homelessness. Households that are not eligible for dedicated prevention assistance are connected to mainstream benefits and other community resources that may help resolve the housing crisis. The CoC also works with community partners to expand the reach of prevention and diversion beyond the homeless response system, including organizations that may encounter households before they become homeless. Over the next 12 months, the CoC will continue using HMIS and CES data to monitor first-time homelessness, identify changes in the circumstances preceding homelessness, and use those findings to inform prevention and diversion strategies and partnerships. The George Washington Regional Commission, as the CoC Lead Agency, is responsible for overseeing the CoC's strategy to reduce the number of individuals and families experiencing homelessness for the first time.

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

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

(limit 2,500 characters)

The CoC's strategy to reduce the length of time individuals and families remain homeless begins at entry into the homeless response system. Coordinated Entry System (CES) providers engage households in housing-focused conversations from initial contact and work with participants to identify opportunities to resolve their housing crisis and return to permanent housing as quickly as possible. When self-resolution is not possible, households are assessed through CES and connected to available housing resources. The CoC uses a community-wide prioritization process to ensure that limited housing resources are targeted to households with the greatest needs, including individuals and families who have experienced the longest periods of homelessness. HMIS data regarding consecutive time homeless and total months homeless are incorporated into the prioritization process. Once matched to a housing resource, providers assist participants with housing search, documentation, applications, lease-up, rental assistance when available, and case management to reduce the time between referral and permanent housing placement. The CoC also works to address system-level barriers that contribute to longer episodes of homelessness. Housing location efforts focus on identifying available affordable units, maintaining relationships with landlords, and assisting households with significant housing barriers. Regular case conferencing allows providers to identify households experiencing prolonged homelessness, troubleshoot barriers to housing, and coordinate resources across agencies. Over the next 12 months, the CoC will continue strengthening its CES, including its governance structure, prioritization and referral processes, and use of data to identify delays between entry, referral, and housing placement. The CoC will use HMIS and system performance data to monitor length of time homeless, identify bottlenecks, and work with providers on strategies to reduce delays. The George Washington Regional Commission, as CoC Lead Agency, will oversee implementation of this strategy in coordination with CoC housing and service providers.

2A-7.	Successful Permanent Housing Placement—Exits to Unsubsidized Housing.	
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Based on HMIS data, what percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing?	42.00%
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Describe how you calculated the data for this response.

(limit 2,500 characters)

An APR report of all HMIS participating TH/RRH/PSH projects was ran for 7/1/2025-6/30/2026. The percentage above is the number of participants exiting to permanent situations without an ongoing housing subsidy divided by the total number of participants exiting the program.

2A-8.	Housing Inventory Count (HIC) and Point-in-Time (PIT) Count Date.	
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	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/28/2026
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2A-8a.	HIC and PIT Count Data—HDX 2.0 Submission Date.	
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	Did your CoC submit its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count data in HDX 2.0 by April 30, 2026, 8:00 p.m. EDT?	Yes
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2A-8b.	Longitudinal System Analysis (LSA) Data—HDX 2.0 Submission Date.	
	You must upload your CoC's FY 2026 HDX Competition Report to the 4A. Attachments Screen.	

	Did your CoC submit at least two usable LSA data files to HUD in HDX 2.0 by January 16, 2026, 11:59 p.m. EST?	Yes
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2A-8c.	System Performance Measures (SPM) Data—HDX 2.0 Submission Date.	
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	Did your CoC submit its FY 2025 System Performance Measures data in HDX 2.0 by March 4, 2026, 8:00 p.m. EDT?	Yes
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2A-9.	HMIS and Comparable Database Participation—Bed Coverage Rate.	
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Using the FY 2026 HDX Competition Report we issued your CoC, enter data in the chart below by project type:

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	63	32	95	100.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	14	0	14	100.00%
4. Rapid Re-Housing (RRH) beds	63	44	107	100.00%
5. Permanent Supportive Housing (PSH) beds	235	0	156	66.38%
6. Other Permanent Housing (OPH) beds	0	0	0	0.00%

2A-9a.	Partial Credit for Bed Coverage Rates of 84.99 Percent or Lower for Any Project Type in Question 2A-9.	
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For each project type with a bed coverage rate that is 84.99 percent or lower in question 2A-9, describe:

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

(limit 2,500 characters)

The Fredericksburg Regional CoC's PSH bed coverage rate is below 85 percent because HUD-VASH beds serving the CoC are not currently represented in the CoC's HMIS. The CoC's other participating PSH projects enter data into HMIS; therefore, increasing PSH coverage will require addressing the gap associated with HUD-VASH. Over the next 12 months, the CoC and HMIS Lead will work with the Central VA Medical Center to determine the appropriate process for increasing representation of HUD-VASH beds in HMIS and improving PSH bed coverage. The CoC will identify the VASH beds included on the Housing Inventory Count, review the specific gap between HIC inventory and HMIS participation, and work with VA partners to address data-sharing, participation, or other implementation barriers that prevent those beds from being represented in the system. The CoC will monitor PSH bed coverage throughout the year and use the annual HIC process to verify VASH inventory and measure progress toward the goal of achieving at least 85 percent PSH bed coverage. The CoC will maintain regular communication with VA partners and provide HMIS technical assistance as needed to implement any feasible changes identified through this process.

3A. Policy Initiatives

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

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

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

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

3A-2	Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.
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Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes? No

4A. Attachments Screen For All Application Questions

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

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

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

1.	You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.		
2.	You must upload an attachment for each document listed where 'Required?' is 'Yes'.		
3.	We prefer that you use PDF files, though other file types are supported—please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.		
4.	Attachments must match the questions they are associated with.		
5.	Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process.		
6.	If you cannot read the attachment, it is likely we cannot read it either.		
	. We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).		
	. We must be able to read everything you want us to consider in any attachment.		
7.	After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.		
8.	Only use the 'Other' attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.		
Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	1C-1. List of TH/...	09/24/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	VA-514: List of C...	09/24/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	VA-514: 1C-3. Lan...	09/29/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	VA-514: 1C-10. Ev...	09/24/2026
05. 1D-1. Local Competition Scoring Tool	Yes	VA-514: 1D-1. Loc...	09/24/2026

06. 1D-2c. Local Competition Selection Results	Yes	VA-514 - 1D-2c. L...	09/25/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	VA-514: 2A-8b. FY...	09/24/2026
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: VA-514: List of CoC Program Projects and Number of Units that require Substance Abuse Treatment

Attachment Details

Document Description: VA-514: 1C-3. Language from Project Supportive Service Agreements

Attachment Details

Document Description: VA-514: 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety

Attachment Details

Document Description: VA-514: 1D-1. Local Competition Scoring Tool

Attachment Details

Document Description: VA-514 - 1D-2c. Local Competition Selection Results

Attachment Details

Document Description: VA-514: 2A-8b. 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	09/25/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/29/2026
1C. Coordination and Engagement	09/29/2026
1D. Project Review/Ranking	09/29/2026
2A. HMIS Implementation	09/29/2026
3A. Policy Initiatives	09/29/2026
4A. Attachments Screen	09/29/2026
Submission Summary	No Input Required

VA-514:
Fredericksburg Regional CoC
FY26 CoC Program Application

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

TH/RRH/PSH Project	Project Type	On-Site SUD Treatment?	On-Site Provider
Micah Ecumenical Ministries: Hesed House	TH	Yes	Fredericksburg Christian Health Center, RACSB
Micah Ecumenical Ministries: HUD CoC Supportive Housing	PSH	Yes	Fredericksburg Christian Health Center, RACSB
Micah Ecumenical Ministries: HTF Supportive Housing	PSH	Yes	Fredericksburg Christian Health Center, RACSB
Micah Ecumenical Ministries: HTF Rapid Rehousing	RRH	Yes	Fredericksburg Christian Health Center, RACSB
Micah Ecumenical Ministries: VHSP Rapid Rehousing	RRH	Yes	Fredericksburg Christian Health Center, RACSB
Micah Ecumenical Ministries: Unsheltered Rapid Rehousing	RRH	Yes	Fredericksburg Christian Health Center, RACSB
Loisann's Hope House: HTF Rapid Rehousing	RRH	No	N/A
Loisann's Hope House: Youth Rapid Rehousing	RRH	No	N/A
Loisann's Hope House: VHSP Rapid Rehousing	RRH	No	N/A
RACSB: DBHDS Supportive Housing	PSH	Yes	RACSB
VA: VASH Vouchers	PSH	Yes	VA
Volunteers of America: SSVF	RRH	No	N/A
Empowerhouse: VHSP Rapid Rehousing	RRH	No	N/A
Empowerhouse: HTF Rapid Rehousing	RRH	No	N/A
Empowerhouse: HUD Rapid Rehousing	RRH	No	N/A
Empowerhouse: HUD Rural Rapid Rehousing	RRH	No	N/A

Total TH/RRH/PSH Projects: 16

Projects with On-Site SUD Treatment: 8

Percentage of Projects with On-Site SUD Treatment: 50%

VA-514:
Fredericksburg Regional CoC
FY26 CoC Program Application

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

Project Name	Project Type	Total Number of Units	Units Requiring SUD Treatment?	Explanation
Micah Ecumenical Ministries: HUD CoC Supportive Housing	PSH	30	No	Project purpose is permanent supportive housing; SUD treatment is not a condition of continued participation
Empowerhouse: HUD Rapid Rehousing	RRH	28	No	Project purpose is rapid rehousing; SUD treatment is not a condition of continued participation
Empowerhouse: HUD Rural Rapid Rehousing	RRH	7	No	Project purpose is rapid rehousing; SUD treatment is not a condition of continued participation

Total CoC Program-funded units requiring engagement in substance abuse treatment as a condition of continued participation: 0

None of the CoC's current CoC Program-funded housing projects have substance abuse treatment as **the purpose** of the project. Accordingly, these projects do not require participants to engage in substance abuse treatment as a condition of continued participation. While projects connect participants to substance use treatment and recovery services when appropriate and may provide those services on-site, participation in those clinical services is not a condition of continued participation in the housing program, consistent with 24 CFR 578.75(h).

VA-514:
Fredericksburg Regional CoC
FY26 CoC Program Application

Attachment 1C-3:
Language from Project Supportive Service Agreements

Provider	Project Types	Require program Participants to take part in Supportive Services?	Excerpt Included below?	Program Agreement Attached?
Micah Ministries	TH, RRH, PSH	Yes	Yes	Yes
Loisann's Hope House	RRH	Yes	Yes	Yes
Volunteers of America	RRH (SSVF)	Yes	Yes	Yes
Empowerhouse	RRH	Yes	Yes	Yes
Central Virginia VA Medical Center	PSH (VASH)	Yes	Yes	Yes
RACSB	PSH	Yes	Yes	Yes

Number of housing projects (TH/PSH/RRH): 8

Number of Projects requiring supportive services: 8 (100%)

Micah Ministries - Program Agreement

Pg. 1 "As a program participant, I/we _____ agree:
_____ To be an active participant(s) in the development and revision of my/our success plan
_____ To work collaboratively with my/our assigned Case Manager, other service providers and my landlord to maintain my housing
_____ To meet with my/our Case Manager at the following frequency:
_____ To allow my/our Case Manager to meet in my home
_____ To comply with the master lease for the unit I/we am renting and the other terms and conditions of this agreement.

Pg. 2: "Failure to meet program expectations at any time could result in the following:

- Written notice of the failure to meet program expectations.
- A meeting with the Housing Team to receive continued services
- Termination of financial funding and services, of which you will be notified in writing."

Loisann's Hope House – Program Agreement

Pg. 1 "Participant Responsibilities:

1. To meet with your Housing Counselor with a frequency established through your assessment process;
2. To provide at least 24 hour notice when cancelling an appointment, and to make every effort to reschedule
3. To work consistently towards the goals outlined on your housing plan;
4. To be open and honest with your Housing Counselor about your presenting situations;
5. To inform staff of changes to your income or financial status;
6. To address barriers that prevents or hinders self-sufficiency.

Pg. 2 "Termination/ Exit Procedure:

- A. Termination by Staff: Termination from the program may occur in extreme circumstances. Events that may constitute termination may include but are not limited to:
 - a. Failure to adhere to the responsibilities listed in the lease agreement
 - b. Any act of fraud, such as failing to report financial assistance received, failing to report income, or misreporting income
 - c. Failure to contact your housing counselor within 30 days"

Volunteers of America – Participant Agreement

Pg.1 “ As a participant in the SSVF Program I/We,

Agree (Please check all that you agree with):

☐ *To complete an intake and provide all necessary information and required documentation for consideration*

☐ *To be an active participant in the development of my Housing Stability and Sustainability Plan (HSSP).*

☐ *To work collaboratively with my case manager, other community partners, and landlord/leasing office to maintain my housing.*

☐ *To meet with my case manager as often as deemed necessary*

☐ *To place a focus on increasing income for increased housing stability; if appropriate*

☐ *To allow my case manager to meet me in my home (via video or in person)*

☐ *To participate in employment workshops, and/or financial literacy workshops, as mandated by your case manager at the time of enrollment or at recertification and place an emphasis on budgeting*

☐ *To respond to correspondence (whether text, email, or phone calls) within 48 hours*

I further understand that failure to comply with the above-mentioned statements could result in the following:

- *A meeting with members of the SSVFP Team to discuss the need for ongoing services*
- *A discontinuation in the SSVFP Team providing financial resources and services to maintain housing or placement into housing*
- *In a termination of the SSVFP funding and services”*

Empowerhouse – Participant Agreement

Pg. 2 “*Applicants must be...*

....Willing and desiring to participate in the Empowerhouse Housing Program and meet with staff monthly;”

Central Virginia VA Health Care System – HUD-VASH Veteran Handbook

Pg. 2. “*HUD-VASH is a case management program with a housing component.*

*Case management, or the management of Veterans’ care and individual needs by assigned VA staff, is a **mandatory** part of the HUD-VASH experience.”*

Rappahannock Area Community Services Board

“Have your case manager over for regular face to face home visits at least every 30 days, but more often if you need. We recognize that unexpected events happen, excessive rescheduling or not being home at scheduled times could lead to termination from the program.”

MICAH ECUMENICAL MINISTRIES

Journey Housing Program of Micah Ecumenical Ministries

Program Agreement

PURPOSE

Welcome to the Journey Housing Program of Micah Ecumenical Ministries. This agreement was created to provide clear understanding of program expectations and to ensure that participant rights are respected and maintained. It outlines tenant responsibilities as a participant in this housing project, which offers rental placement, guidance, financial assistance and case management to homeless individuals in transition to permanent housing.

PROGRAM UNDERSTANDING

While enrolled in the housing program, Micah will pay a portion of the your household's rent, all subject to your compliance with the terms and conditions provided hereunder and available funding. The purpose of this assistance is to give you time to stabilize into permanent housing, explore ways that you can increase your skills and or income, and to assist in improving your self-determination. As part of the housing program, you will work closely with your case manager to develop a success plan. We encourage you to consider goals that will allow you to utilize one or more of Micah's stabilization programs (i.e. SOAR, Step Forward, PATH, HealthBridge, etc.) and to not be solely dependent on our assistance or that of our housing team who work with us. Based on your success plan, Micah will put together a housing team to assist you with accomplishing the necessary steps to maintain housing.

As a program participant, I/we _____ agree:

- _____ To be an active participant(s) in the development and revision of my/our success plan
- _____ To work collaboratively with my/our assigned Case Manager, other service providers and my landlord to maintain my housing
- _____ To meet with my/our Case Manager at the following frequency: _____
- _____ To allow my/our Case Manager to meet in my home
- _____ To comply with the master lease for the unit I/we am renting and the other terms and conditions of this agreement.

CASE MANAGEMENT

Housing case managers have an obligation to follow-up with participants placed in housing. Should a case manager be unable to contact the participant three consecutive times, he/she may visit unannounced in the interest of immediate health and safety concerns.

RENTAL OBLIGATION

A letter of support to your landlord is attached to this agreement. It details the projected amount that you and Micah are obligated to pay for the duration of the program. Your signature below indicates that you acknowledge and accept the initial pledged rental amounts, which will be reviewed monthly.

FINANCIAL ASSISTANCE

The financial assistance associated with this program is temporary for individuals that were once homeless and need assistance to become stable. Participants who work closely with their housing team and follow their success plan will have a better chance at sustaining their housing after transitioning off the program. Notwithstanding anything to the contrary hereunder, all financial assistance is subject to your cooperation in providing income/asset documentation and available funding.

RECERTIFICATION

State and federal guidelines require that Micah staff evaluate your progress and consider whether an extension is appropriate. Evaluations include review of the following:

- Compliance with the program agreement
- Success plan accomplishments
- Current income and assets
- Need for supportive services

CHANGES IN RENTAL OBLIGATIONS

If Micah staff decides an increase or decrease in rent paid by the organization or program participant is necessary, both the landlord and program participant will receive 30 days written notice prior to the implementation of the change.

TERMINATION

Failure to meet program expectations at any time could result in the following:

- **Written notice of the failure to meet program expectations.**
- **A meeting with the Housing Team to receive continued services**
- **Termination of financial funding and services, of which you will be notified in writing.**

I/We agree with the terms and requirements to receive financial funding and services. I/We also understand that providing false information may result in disqualification/termination from the program. This is not an entitlement program. Decisions on participation are based on a review of information about a household and whether that household meets the criteria that are outlined in the program regulations, the availability of funds and staff needed for participation.

Participant Signature

Date

Participant Signature

Date

Staff Signature

Date



PARTICIPANT RIGHTS, RESPONSIBILITIES AND PROCEDURES

The purpose of this program is to provide ongoing support to help you stabilize your household, move into permanent housing after experiencing homelessness, or prevent homelessness before it occurs. This program agreement is designed to provide a clear understanding of the policies and procedures. In this agreement, the rights and responsibilities of both you and your Housing Counselor are outlined. Our primary goal is to provide services to help you become self-sufficient. This program works best as a partnership, and your engagement and participation are just as important as the support we provide. We look forward to working together on your journey!

I. Notice of Rights and Responsibilities: As a participant being served by this agency, your rights are protected by government regulations. The following is a summary of these rights:

A. Participant Rights

1. To be treated with dignity and respect;
2. To receive services regardless of your race, national origin, sex, age, religion, or disability;
3. To be protected from harm including abuse, neglect and exploitation
4. To terminate your services at any time;
5. To determine the goals set forth in your service plan.

B. Staff Responsibilities

1. To build a trusting relationship through honesty and respect;
2. To be open to discussing your needs and ideas;
3. To provide opportunities to increased employment and life skills;
4. To link you with services within the community for which you are eligible;
5. To assist you in establishing attainable goals and help you achieving them;
6. To respond to your concerns and requests in a timely manner

C. Participant Responsibilities

1. To meet with your Housing Counselor with a frequency established through your assessment process;
2. To provide at least 24 hour notice when cancelling an appointment, and to make every effort to reschedule
3. To work consistently towards the goals outlined on your housing plan;
4. To be open and honest with your Housing Counselor about your presenting situations;
5. To inform staff of changes to your income or financial status;
6. To address barriers that prevents or hinders self-sufficiency.

II. Confidentiality

1. Program Participant files will be stored in a locked file cabinet in a secured location and will not be available to others who are not authorized to have access. Program participant files do not leave the building.
2. If disclosure of information is deemed necessary, Housing Counselors will inform you before the disclosure, to the extent possible, and will disclose the least amount of confidential information necessary to achieve the desired purpose. Only information directly relevant to the purpose for which the disclosure is made will be revealed.



3. To confidential handling of records;
Staff reserves the right to break confidentiality if: The staff member suspects abuse or neglect of a child or elder, staff feels that you are in immediate danger or harm to self or others, or staff is court ordered to legal proceedings where case notes and case information have been subpoenaed
4. Copies and printed materials with your information on them will be shredded, destroyed or archived when no longer in use.
5. All program participant meetings and/or discussions of confidential nature will be held in settings where privacy can be ensured (e.g. closed offices, conference rooms, consultation rooms).
6. If mail is received at the program location, it will be distributed to you directly by a staff member.

III. Housing Counselor Services: You and your Housing Counselor will work closely together to identify barriers you are facing and setting reasonable and attainable short and long-term goals to help you work toward self-sufficiency. These goals will be outlined in your housing plan and can include, but, are not limited to:

- A. **Housing:** You will have access to a Housing Locator who will be able to assist you with maintaining current housing, access more affordable permanent housing options, understand the process of locating and maintaining housing, and answer any additional questions that you may have as part of the housing process.
- B. **Employment/Increasing Income:** Your Housing Counselor can help you access employment options and identify ways to increase your income. Participants are encouraged to enroll in vocational training if increased skills are needed.
- C. **Financial:** Families will work with their Housing Counselor to develop and adhere to strategies to better manage their budget, increase savings, and improve credit. Families will submit documentation of these to their Housing Counselor.
- D. **Health:** Access to health care services or benefits
- E. **Children's Services:** Tutoring, counseling, child care, etc.
- F. **Access to Substance Use Treatment and Recovery Support**
- G. **Legal/Immigration Resource Referrals**
- H. **Mental Health**

IV. Termination/ Exit Procedure:

- A. Termination by Staff: Termination from the program may occur in extreme circumstances. Events that may constitute termination may include but are not limited to:
 1. Failure to adhere to the responsibilities listed in the lease agreement
 2. Any act of fraud, such as failing to report financial assistance received, failing to report income, or misreporting income
 3. Failure to contact your housing counselor within 30 days

Immediate termination from the program would occur in the event of the following circumstances:

1. Any real or perceived threat of violence or actual act of violence committed against a housing counselor or other staff;



PROGRAM AGREEMENT

2. Possession of illegal drugs or alcohol on agency property
 3. Use or possession of illegal weapons or firearms on agency property.
- B. Termination by Participant: You have a right to terminate your services at any time. Doing so will result termination of all financial assistance and other services. If you wish to re-enter the program following a voluntary termination you will be required to go through the original application/referral process

Participant: _____ Date: _____
Print Name

Participant: _____
Signature

Staff: _____ Date: _____
Print Name

Staff: _____
Signature

Supportive Services for Veteran Families Program

Participant Agreement Form

As a participant in the SSVF Program I/We,

Agree (Please check all that you agree with):

- ☐ To complete an intake and provide all necessary information and required documentation for consideration
- ☐ To be an active participant in the development of my Housing Stability and Sustainability Plan (HSSP).
- ☐ To work collaboratively with my case manager, other community partners, and landlord/leasing office to maintain my housing.
- ☐ To meet with my case manager as often as deemed necessary
- ☐ To place a focus on increasing income for increased housing stability; if appropriate
- ☐ To allow my case manager to meet me in my home (via video or in person)
- ☐ To participate in employment workshops, and/or financial literacy workshops, as mandated by your case manager at the time of enrollment or at recertification and place an emphasis on budgeting
- ☐ To respond to correspondence (whether text, email, or phone calls) within 48 hours

I further understand that failure to comply with the above-mentioned statements could result in the following:

- A meeting with members of the SSVFP Team to discuss the need for ongoing services
- A discontinuation in the SSVFP Team providing financial resources and services to maintain housing or placement into housing
- In a termination of the SSVFP funding and services

I agree with the terms and requirements to receive SSVFP Services, and understand the goal of the program is permanent, sustainable housing. Permanent housing is defined as a space (Eg: room, apartment, townhome, etc.) being occupied by you under a lease executed in your name. I also understand that providing false information may result in disqualification/termination from the program. **I understand that SSVF is not an entitlement program or rent payment program.**

Decisions on participation are based on a review of information about a household and whether that household meets the criteria that are outlined in the federal program regulations, the availability of funds and staff needed for participation.

Consumer Signature

Date

Consumer Signature

Date

Staff Signature

Date



EMPOWERHOUSE HOUSING APPLICATION

We are glad you are interested in applying for the Empowerhouse Housing Program. The mission of this housing program is to assist survivors of domestic violence in gaining economic stability and achieving their personal goals. We strive to meet this mission by providing a variety of practical and emotional support, housing assistance, and other optional supports such as the employment specialist services.

Described here are the eligibility criteria and some basic program information. This application is used to determine whether you are eligible and whether this program can offer you the support and assistance you desire. The questions in this application are included solely as a way of establishing whether this program is a good fit for your needs and situation. You have the right not to answer any question you believe not necessary to determine eligibility.

Please complete this application and return it to a staff member. Once the housing staff receives your application, we will review it and contact you within 3 business days. If you are eligible, we will set up a time to meet and get to know each other better, to determine whether this is a good fit.

If you need any assistance with interpreting or completing this application please do not hesitate to tell a staff member.

Thank you for your interest. We look forward to hearing from you.

Eligibility Criteria

Determination of acceptance into The Empowerhouse Housing Program will be made on a case by case basis, based on the following minimum criteria and guidelines.

Applicant must be:

- ◆ A survivor needing housing due to domestic and/or sexual violence, dating violence or stalking.
- ◆ Eighteen years old or (legally) emancipated minor;
- ◆ In need of housing because of the abuse without sufficient emergency or transitional housing available;
- ◆ Willing and desiring to participate in the Empowerhouse Housing Program and **meet with staff monthly**;
- ◆ Willing to create an individualized safety plan, with the assistance of Empowerhouse staff; and
- ◆ Able to safely* live independently, without access to staff or support 24-hours per day, 7 days per week.

* The Empowerhouse Housing Program recognizes that the applicant does not have control over the batterer's behavior or the behavior of people associated with the batterer. The Empowerhouse Housing Program strives to help each participant maintain the safest life possible, and will not exclude participation or withhold assistance based on batterer's behavior.

Empowerhouse Housing Program Information

The Empowerhouse Housing Program can provide subject to available resources:

- ◆ Financial assistance for security deposit and first month's rent
- ◆ Advocacy and emotional support, including counseling and case management
- ◆ Assistance finding and maintaining permanent housing
- ◆ Safety planning and safety devices for your home
- ◆ Vocational and employment assistance
- ◆ Assistance with transportation, childcare, and household furnishings
- ◆ Other assistance determined by applicant if an eligible expense and if resources are available
- ◆ Referrals to community resources and services
- ◆ Follow-up services, for a minimum of 3 months, upon exiting the Empowerhouse Housing Program

Housing Program Guidelines

Dear Applicant,

Congratulations! You have met the eligibility criteria and have been accepted into Empowerhouse's Housing program. This begins a journey toward stable housing and economic stability through housing supports and opens to you the supportive services of two employees working with the program including the Housing Advocate, Housing Case Manager and the Rappahannock Goodwill Industries (RGI) Employment Specialist and Workforce Education Resource Navigator

The Housing staff members at Empowerhouse and RGI are committed to helping survivors of domestic violence achieve their goals with an emphasis on promoting the safety of survivors and their children and economic stability.

The above listed individuals are available to you as a united team to help you define your goals and identify strategies to reach your goals. However, at this time we do not know if you will choose to live on your own, with a friend, or family, etc. We do not know which individuals enrolled in this program will proceed to a rental unit and lease signing related to barriers that some individuals experience. Some or all of the following, if they apply, may slow down the process: credit issues, past issues surfacing from background checks, nonpayment of past due rent or utilities previously owed, documented status, or other barriers that may require some time to address and/or overcome. Some barriers, in some situations, may keep some individuals from accessing the rental assistance portion of the housing program. We will work with you to help you overcome barriers if you desire, and toward the housing arrangement you believe best fits with your goals, plans, and efforts while you work on housing security and economic security measures. Your goals and efforts matter in determining what your housing arrangements will be. Honesty with staff about your individual situation will help the housing team support your goals.

Page 1 of 4



If you are able to sign a lease with a landlord/rental property the following guidelines must be understood:

Please initial below, next to each policy, indicating that you have read and understand the terms of this contract.

Program Guidelines

- 
- ☐ 1. I understand that the lease for my apartment or rental property will be in my name and that I will be held legally responsible for breaking the lease or not abiding by the rules as designated by my lease.
- ☐ 2. I understand that this program is for survivors of domestic violence and their dependents only, and that I will be in violation of Empowerhouse's program and the apartment/rental property lease if I allow another adult to reside with me.
- ☐ 3. I understand that in order to have the Housing team assist me to their fullest capacity I must meet on a regular basis with team members to discuss any concerns either I or the team may have on my behalf.
- ☐ 4. I understand that the period of time I am in this Housing Program is based on when I enter the program during the cycle of the grant (some grant funds may be time limited or end their cycle while a participant may still have needs).
- ☐ 5. As this Housing Program is designed to empower individuals who want to become self sufficient at the end of their program period, I understand that I will be responsible for paying a percentage of my rent while in this program and my rent in its entirety upon completion of this program.
- ☐ 6. I understand that my Housing Program eligibility including rental assistance is contingent upon me and my children's adherence to Empowerhouse's program guidelines as well as the lease of the apartment/rental property.
- ☐ 7. I understand that this contract may be broken by Empowerhouse at any time during the above stated period if I am asked to leave the program due to an infraction of any of Empowerhouse's guidelines or the apartment complex's lease, rules, and regulations.

Building and Personal Security/Safety Planning

- ☐ 1. I have reviewed the personalized safety plan with my Victim Advocate at Empowerhouse and fully understand the guidelines, policies and procedures in order to promote my safety and/or that of my children.
- ☐ 2. I shall use discretion when giving my new address or house/apartment location information to anyone during my stay in the Housing Program or after I leave the program.
- ☐ 3. I understand that funds may be available from the grant in order to assist me with obtaining a post office box.

Rent

- ☐ 1. I understand that remaining in the Housing Program is contingent upon paying my portion of the rent.
- ☐ 2. I understand that if payment is late, I will be assessed late fees and if a payment is missed, I may be asked to leave the program. It is my responsibility to inform the Housing Victim Advocate if I am experiencing financial difficulty as soon as I become aware of any challenges.
- ☐ 3. I understand that if I leave the Housing Program or I am terminated I will be responsible for any rent that is due and owing to my landlord, and I will be responsible for any cleaning fees and damages done to the unit while in this program.
- ☐ 4. I will return the rental deposit at the end of the program if I leave the unit and it is not needed for my safe relocation to other housing.

Grievance and Appeals

- ☐ 1. I have read, or it has been read to me, and I understand the Grievance and Appeal Procedure.

Alcohol, Drugs, Weapons and Illegal Behavior

- ☐ 1. I understand that using illegal drugs and bringing illegal drugs (including paraphernalia) into the house or stowing them in my vehicle is against the law and puts me at risk to lose my rental lease.
- ☐ 2. I understand that if I am struggling with an addiction issue, program staff are available for support, referrals, and resources. Those struggling with addiction issues are encouraged to seek support in order to avoid the risk of losing a rental lease, getting into legal trouble, and damaging physical/psychological health.
- ☐ 3. I shall not engage in or permit any illegal behavior to occur on my premises while participating in Empowerhouse's Housing Program.



Program Requirements

- ☐ 1. I agree to abide by all guidelines as stated in my participation in the Empowerhouse Housing Program and the lease and rules designated by the apartment complex/landlord.
- ☐ 2. I will work towards achieving my housing goals I have designed to assist me in obtaining economic stability during my period of time in the Housing Program.

Waiver

- ☐ 1. Empowerhouse and its staff are in no way responsible for any damage or injury to any person who is being housed by Empowerhouse's Housing Program. Neither the Board, nor the staff or the volunteers may be held liable in any way for occurrences which may result in injury or death to me or my family, their heirs, or assigns.
- ☐ 2. Empowerhouse and its staff are in no way responsible for any damage or injury to any person who has received donated items while in Empowerhouse's Housing Program. Neither the Board, nor the staff or the volunteers may be held liable in any way for occurrences which may result in injury or death to me or my family, their heirs, or assigns.



Additional Conditions

- ☐ 1. If I decide to leave my designated place of residence while in Empowerhouse's Housing Program I must notify Empowerhouse's Victim Advocate as well as give at least 60 days prior notice in writing to my landlord/apartment complex manager.

I have read, or it has been read to me, and I understand the Housing Program Guidelines. Any violations are subject to consequence through Empowerhouse and the apartment complex/landlord.

Date

Client Signature

Date

Staff Signature

HUD-VASH VETERAN HANDBOOK



Central Virginia VA Health Care System

VASH Operating Hours: 8am to 4:30pm, Monday – Friday

HCHV Office telephone number and location: 804-675-5000 x 2041

Room 1D104

HUD-VASH - Orientation

Welcome to HUD-VASH; we are very happy to have you with us!

VASH stands for Veterans Affairs Supportive Housing. The HUD-VASH Program is a partnership that was developed by the VA with the Department of Housing and Urban Development (HUD) to provide permanent housing and supportive services to homeless and chronically homeless Veterans. The primary mission of HUD-VASH is to “move Veterans and their families out of homelessness” (VHA Handbook, 1162.05, p.1) through a housing-first model of care. In doing so, the HUD-VASH program works to support the VA’s overall mission: to fulfill President Lincoln's promise "to care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans.

HUD-VASH is a *case management* program with a housing component.

Case management, or the management of Veterans’ care and individual needs by assigned VA staff, is a **mandatory** part of the HUD-VASH experience. HUD-VASH staff at Central Virginia VA Healthcare System work together in a team-based shared caseload approach to most effectively serve our Veterans; however, you will be assigned a primary case manager for the initial pre-engagement phase and a primary case manager upon receiving your housing choice voucher. Case management is a continuous, collaborative process between each Veteran and their assigned VASH team. In the HUD-VASH program, case management services are designed specifically to improve a Veteran’s wellness, aid in his/her recovery, and enhance his/her ability to live in safe and affordable permanent housing. There must be ongoing and continuous communication between the HUD-VASH team and a Veteran in order for the Veteran to meet his/her goals.

HUD-VASH case management definition:

- Case management is provided based on a Veteran’s individual goals and needs. Veterans are generally involved in case management for at least one year prior to a discussion of HUD-VASH “graduation,” or positive discharge from the case management component of the program.
- The level or stage of case management is determined through a combination of an objective acuity tool, clinician’s assessment, and Veteran’s preference

- Veterans are required to meet with their case management team for a minimum frequency depending on the phase of case management. Case management visits typically occur face-to-face in the Veteran's home when possible; however, VVC technology is offered and utilized when face-to-face visits are not able to occur. Please refer to chart below.

Stage of Case Management	Minimum Visit Standards	Definition of Stage
Pre-engagement	Weekly	Orientation to HUD-VASH program, assistance with obtaining all vital documents, development of initial treatment plan, initial housing search assistance
Intensive	Weekly	Meet with case management weekly while searching for housing and thereafter remains in this stage as needed when housed
Stabilization	Twice Monthly	Veteran is housed and is no longer in intensive stage of case management.
Maintenance	Monthly	Veteran is no longer in stabilization stage.
Preparation for Discharge	Quarterly	Veteran is no longer in maintenance stage, is preparing to graduate, and is seen quarterly.
Graduation	Yearly	Veterans are living successfully in permanent housing for at least one year, have met all personal goals, have completed case management. Veterans will only receive an annual call from the aftercare case management team to check in regarding status and to review VASH Veteran Handbook.

HUD-VASH Process

1. Screening

Veterans who meet program eligibility, including homelessness as defined by defined in the McKinney-Vento Homeless Assistance Act, being below the income threshold to obtain a housing choice voucher, and a need/willingness to engage in case management services, can be referred to HUD-VASH directly from a walk-in intake or through the community coordinated entry system. All referrals are reviewed on a weekly basis and are reprioritized weekly to align with VHA Directive 1162.05. Pending voucher and staffing availability, Veterans with the highest need are identified and transition into the pre-engagement phase of the HUD-VASH program.

2. Pre-engagement Orientation

Veterans are assigned to a primary case manager for the purpose of the pre-engagement phase. The primary goals of this phase are to receive formal orientation to the HUD-VASH program, including the purpose of the program, structure, and policies, obtain vital documents required to submit to the public housing authority to receive a housing choice voucher, complete initial treatment planning, and begin searching for housing. Additionally, Veterans receive education about their rights and responsibilities in the HUD-VASH program.

Veterans who are willing to participate in HUD-VASH and comply with the program's rules must sign and date the Veteran's Service Agreement.

The timeline for pre-engagement can range from 1 visit to several weeks, depending on how long it takes to obtain vital documents. After a referral is placed to the public housing authority to request a housing choice voucher, the voucher orientation can take up to two weeks to be scheduled by the public housing authority. During this time, Veterans are encouraged to attend the Housing Orientation group facilitated by the HUD-VASH Housing Specialist and held the 2nd and 4th Friday of each month from 10-11am in 2B-130.

3. Transition to primary case manager

Our HUD-VASH program uses shared caseloads and a team-based model of care to provide the best care for our Veterans. As such, after the referral to the housing authority has been made, your pre-engagement case manager will provide a warm hand-off to your assigned primary case manager, who works closely in a teamlet with other social workers that you will get to know and work with over the course of your involvement with HUD-VASH. Your primary case manager is responsible for ongoing case management services, including contact with you, the public housing authority (PHA), and the landlord. Quarterly treatment plans will be developed between you and your primary case manager to review progress toward identified case management goals.

4. Voucher Briefing

Your primary case manager will alert you to the date/time/location of your voucher briefing appointment at the public housing authority and can provide support prior to

and during this appointment. Additional paperwork will be completed **in-person** at this appointment with the Housing Authority Specialist. Due to COVID-19 precautions, some housing authorities have transitioned to virtual appointments, and your HUD-VASH case manager can provide additional details. Your voucher is yours for life as long as you INCOME-QUALIFY annually and remain in compliance with Section 8 Family Obligations.

5. Housing search

- Once a Veteran receives a voucher, the Veteran can begin applying for housing. Veterans must continue to meet with either housing specialist or their primary case manager weekly to provide updates and receive assistance with the housing search.
- Once you have identified a unit that accepts housing choice vouchers and is able to accommodate any housing barriers you may have (such as previous evictions, poor credit history, etc), apply to the unit.
- Once accepted, a request for tenancy agreement (RFTA) must be given from the Veteran to the landlord to complete (see frequently asked questions for more details). The RFTA is returned to the public housing authority who sends out an inspector to ensure the unit is up to code.
- Once the unit passes inspection, you will be notified by your case manager that you can sign your lease. Additionally, a housing assistance payment (HAP) contract will be signed between the landlord and housing authority.
- Move in to your new home!

6. Discharge

There are two types of discharges from HUD-VASH:

Graduation – The possibility of graduation is discussed when Veterans reach their goals and the Veteran no longer needs case management. Although formal HUD-VASH case management services stop upon graduation, you will be contacted annually by an aftercare case management team regarding your status and rights and responsibilities. Additionally, if emergent case management needs arise after graduation, you are encouraged to contact your HUD-VASH case manager or office. A HUD-VASH staff member will assess for acute vs. chronic case management need and

will assist the Veteran appropriately, which may include re-entering formal case management services for a period of time.

Discharge – Based on HUD regulations, Veterans who violate any of the rules outlined in the Family Obligations Notice can be terminated from the Section 8 program. In this circumstance, the Veteran will be discharged from the HUD-VASH program and the assigned HUD-VASH case manager will assist the Veteran with appropriate transition referrals.

Frequently Asked Questions

What is VVC?

VVC is a secure platform utilized by the VA to provide face-to-face healthcare visits using technology that allows for both the Veteran and the clinician to see and hear each other. VVC can be effectively used on most computers, tablets, or cell phones that have video capability. For Veterans who do not currently have a technological device that has video capability, VA staff can assist the Veteran in obtaining either a cell phone or tablet to support the Veteran's use of VVC technology.

For what payments am I responsible?

- Veteran pays approximately 30-40% of his/her income towards rent and the voucher subsidizes the rest. Payment is due no later than the date specified on the lease agreement.
- If an individual has no income, the minimum payment as of now is \$50.
- Application fees, if any.
- The security deposit, if any. At times there may be funding available through community partners; however, Veterans are encouraged to anticipate contributing at least 10% of their monthly income toward security deposits.
- Furniture and appliances, if not included in the lease agreement. At times there may be funding available through community partners to assist with furniture
- Out-of-pocket fees for utilities, if not included in the lease agreement.
- Veterans with pets are responsible to pay for additional pet fees, if any.
- All other costs of living, including but not limited to groceries, cable, internet, and transportation.

How much is my voucher worth and how many bedrooms will I have on my voucher?

- The Public Housing Authority determines the amount your voucher is worth and number of approved bedrooms. It is based on the number of people on the voucher

and the city/county you choose to reside. An estimate of the maximum allowable rent towards which the Housing Authority will contribute is provided with your voucher from the public housing authority.

Can I use my voucher for an apartment or a house that has more bedrooms than what my voucher was approved for?

- Yes, as long as the rent does not surpass the voucher amount. The landlord and Housing Authority must also agree to accept.

What is in my voucher packet?

- Voucher packets distributed by the public housing authority will include Housing Authority information, resources, housing tips, along with an estimated breakdown of the Veteran's portion of rent and the Housing Authority's contribution towards rent. Also in the voucher packet is a document titled Request for Tenancy Approval (RFTA).

How do I use my RFTA form?

- After the landlord accepts an application, he/she may require a credit and/or background check. After passing the check, if any, the Veteran gives the RFTA form to the landlord to complete (please note that Veteran must sign portions of the completed RFTA as well).
 - The RFTA form must be turned into the Housing Authority from which you were awarded your voucher. A Housing Authority inspector will contact the landlord to schedule an inspection.
 - If needed, Veterans may request a new RFTA form in person at the PHA office.

What is the inspection process like?

The Housing Authority will assign a housing inspector to make an initial inspection of the unit and to conduct annual inspections for as long as you have a voucher. During the yearly inspection, the Housing Inspector will ensure that the unit is free of safety hazards, utilities are turned on, and the unit is appropriately sanitary. The unit must pass inspection in order for a Veteran to be able to move in and/or to continue to utilize the voucher at that particular residence. Due to COVID-19 precautions, some Housing Authority agents are completing inspections virtually.

Veterans should report all damage(s) or malfunction(s) to the property manager in writing immediately and maintain a copy for personal records. Veterans may request assistance from their assigned case management team as needed.

When can I sign my lease and move in?

The lease and move-in occurs after the inspection has passed and a contract is drawn up between the Housing Authority and the landlord. ****If a Veteran signs the lease or moves in prior to receiving approval from the Housing Authority, the Veteran becomes responsible for the full rental amount.****

Use of Supportive Services for Veteran Families (SSVF) for security deposit assistance requires a referral by case manager to be submitted prior to signing the lease and is accessed when deemed necessary and funds are available.

What do I have to report to the Public Housing Authority?

- Any changes in the amount of people living in the unit such as adding or removing an individual from your voucher.
- Vacating unit for 30 days or more (requires letter to be sent to landlord and PHA to obtain permission for rent payments to continue).
- Eviction
- Any changes in income (increase or decrease) must be reported immediately, in writing, to the Housing Authority. Veterans should also inform their assigned HUD-VASH case management team. If there are income changes, the Veteran's portion of rent may increase or decrease accordingly.

What are my responsibilities and rights with regard to the HUD-VASH program?

- Veterans maintain open communication with their assigned HUD-VASH case management team to:
 - Confirm housing status
 - Report changes in contact information
 - Report changes in income
 - Request assistance with referral(s) and other needs
 - Participate in ongoing home visits and case management services beginning when Veteran moves into permanent housing
- **VASH Participant Rights**
As a VASH participant, you have the following rights:

- Freedom from abuse, financial or other exploitation, retaliation, humiliation, or neglect
- Access to your PHI (personal health information) to help inform your decision-making about your care
- Informed consent, or refusal or expression of choice regarding: service delivery, release of information, concurrent services, composition of your VASH case management team
- Access/referral to self-help and advocacy support services, and legal entities to represent you
- Investigation and resolution of alleged infringement of rights.

What happens to my personal information?

Your medical record will be kept confidential per HIPAA (Health Insurance Portability and Accountability Act) requirements. In order for your case management team to discuss any information about the Veteran that pertains to the voucher, lease agreement or emergency, a Veteran must sign a Release of Information (ROI) for each party, e.g. the Housing Authority, landlord, programs to which you apply, emergency contacts.

HUD-VASH staff are mandated reporters, meaning we are required by law to report to protective services any suspected cases of child/elder abuse/neglect. Additionally, HUD-VASH staff are trained to assess for suicidal and homicidal ideation and behaviors and will work with appropriate internal VA staff as well as police as clinically indicated when staff are concerned for the well-being of the Veteran or someone else. Finally, as government employees, HUD-VASH staff are bound to uphold the VHA Code of Integrity. As outlined in the VHA Code of Integrity, *“All VA employees with knowledge or information about actual or possible violations of criminal law related to VA programs, operations, facilities, contracts, or information technology systems shall immediately report such knowledge or information to their supervisor, any management official, or directly to the Office of Inspector General (38 C.F.R. 1.201). Moreover, Federal regulations provide the following guidance regarding reporting fraud, waste and abuse. Employees shall disclose waste, fraud, abuse, and corruption to appropriate authorities (5 C.F.R. 2635.101(b)(11).”*

What is considered appropriate participation in case management?

The communication between the HUD-VASH Veteran and the HUD-VASH case management team must be mutually safe, respectful, and appropriate at all times. If either

the case manager or Veteran feels unsafe during an interaction, the visit can be terminated and rescheduled for a later time.

Grievance Process

Should you disagree with any administrative and/or clinical aspects of your care in HUD-VASH, you have the right to seek an agreeable resolution. Please follow the grievance procedure described below.

Note: This process specifically applies to issues concerning the Central Virginia VA Healthcare System HUD-VASH program, not the Housing Authority or another VA or outside agency.

Step 1: Contact your HUD-VASH case manager. Your HUD-VASH case manager, or designee, must meet with you (in person or by phone) in an attempt to resolve the grievance within **seven business days**.

Step 2: If a satisfactory response is not achieved after a meeting with your HUD-VASH case manager, you may request to have your grievance reviewed with the HUD-VASH Supervisor. **Please call (804) 675-5000 x 2041 to schedule an appointment to discuss your grievance.** You will be contacted by the HUD-VASH Supervisor via phone within **seven business days of your request**. The HUD-VASH Supervisor will review your grievance with you and make a disposition. The details of the grievance and the outcome will be documented in your medical record. You can request a copy of your medical records at any time from Release of Information, located near the front entrance of the hospital.

Step 3: In the event that your complaint cannot be resolved with the assistance of your HUD-VASH case manager or HUD-VASH supervisor, the complaint will be elevated to the Chief, Social Work Service Line, ext 5760.

Step 4: If your complaint has not been resolved after meeting with the Chief of the Social Work Service Line, you may be referred to the Medical Center Patient Experience Center, ext 5455

What if I have a medical or psychiatric emergency?

- In the event there is a medical emergency, please call 911 or go to the nearest Emergency Department.
- In case of a psychiatric emergency, please contact the 24/7 Veteran's Crisis Line at **988 and hit #1**, call 911, and/or go to the nearest Emergency Department.

Please remember that your HUD-VASH case management team, the Public Housing Authority and the Veteran's Health Administration are here to support you. Your case management team will be there to guide you and advocate on your behalf. Thank you for your service.

Certification of Review and Understanding

I have read this HUD-VASH Veteran Handbook and have been oriented to the HUD-VASH program. I certify that I understand this handbook's content and that I understand the following:

- My rights and responsibilities as a participant in the HUD-VASH program.
- I am required to maintain consistent contact with my HUD-VASH case management team and the number of visits are dependent on what phase of case management I'm in.
- The requirements of ongoing contact with case managers and other staff.
- The requirements of appropriate participation in case management.

I will consult with my HUD-VASH case manager if I have any future questions.

Name of HUD-VASH Participant (Please print):	Name of Central Virginia VA Health Care System HUD-VASH Representative (Please print):
Signature:	Signature:
Date:	Date:
Veteran's Last four of SS# _____	

Roles and Responsibilities for PSH Participants

In Permanent Supportive Housing, **we work together as a team. In a team, it is important for everyone to understand their Roles and Responsibilities.**

*(***Participant initials next to each after reviewing with case manager)*

Roles

_____ Identify things that are important to you that you believe will help you stay housed.

_____ Create a plan that makes sense for you to achieve your goals, with the support of your case manager.

Responsibilities

_____ **Have your case manager over for regular face to face home visits** at least every 30 days, but more often if you need. We recognize that unexpected events happen, excessive rescheduling or not being home at scheduled times could lead to termination from the program.

_____ **Turning in all financial documents** within 30 days of request, items such as Annual Social Security Benefits statements, pay stubs (due every month), any change in benefits letters, etc.

_____ **Actively work toward and achieve goals** that you and your case manager have agreed upon.

_____ **It is your responsibility to pay your portion of the rent** (if it is not paid, this could be grounds for eviction). Please speak with your case manager immediately if you are unable to pay your portion.

_____ **Utilities must be kept current** (if they are not, this could be grounds for eviction). Please speak with case manager immediately if you are unable to pay the bill and/or pay the bill in full.

_____ **Actively communicate with your case manager about any issues that come up.** This means being open and honest when communicating with your case manager about what is going on in your life. This also means communicating with your case manager when issues arise with your unit, whether it be a maintenance issue, damage to the unit, or anything else that could result in the unit becoming uninhabitable or you being evicted from the unit.

_____ If you want someone new to join your household and move in with you, **tell your case manager ahead of time.** They will need to make sure this new household member meets eligibility criteria and will not break any terms of the lease, putting your housing at risk.

_____ **You are responsible for maintaining your home according to your lease.** Work with your case manager to understand your lease responsibilities. Things that can put your housing at risk could include guests in and out of your home, obtaining a pet, disturbing your neighbors, cleanliness, or causing damage.

_____ Allow property staff or home inspectors into your unit for scheduled inspections or maintenance.

_____ **Work with PSH staff to make sure that you meet program eligibility.** This includes completing financial recertification with PSH staff, obtaining and signing all required paperwork and allowing staff to perform annual reviews of the apartment to ensure you continue to meet the criteria for PSH.

_____ **You are responsible for not exhibiting threatening or abusive language or behaviors toward others,** like neighbors, landlords, or PSH staff. Any major safety or behavioral concerns could result in termination from the program.

_____ **You are responsible for not committing criminal activity in or around your home,** like buying or selling drugs, or hosting illegal activities in your home. This puts your community's safety at risk and could lead to termination from the program.

_____ It is your responsibility to keep the smoke detector where it is placed by the apartment management and in working order.

_____ **Upon move out from the unit, you are responsible for moving your belongings,** emptying the unit, and cleaning the unit to the condition in which it was prior to your move in. Your case manager will provide you with a moving out checklist to assist with this process if needed and will help to direct activities related to moving out if needed. If the unit is not left in this condition, you may be responsible for any charges accrued over your deposit amount for services such as junk removal, cleaning, etc.

Client Signature: _____

Date: _____

Case Manager Signature: _____

Date: _____

Roles and Responsibilities should be reviewed each year with annual review:

☐ Copy given to tenant

☐ Copy saved in file

VA-514:
Fredericksburg Regional CoC
FY26 CoC Program Application

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

VA-514:
Fredericksburg Regional CoC
FY26 CoC Program Application

Attachment 1D-1:
Local Competition Scoring Tool

Fredericksburg Regional CoC 2026 CoC Program Scoring Sheet

Instructions

Project application scores should reflect the strength of the individual proposal as well as the relative strength of the proposal in comparison to other proposals for the same project type. Scores should also reflect the proposal's ability to demonstrate strong collaboration among the network of projects within the homelessness response system.

Project application scores should inform the final project ranking, but the Funding Committee should also consider other factors, such as project type, population group served by the project, levels of unmet need, or other parameters.

Renewal and expansion requests for the same project will be scored on one scoring sheet but in separate columns. Renewal and expansion requests may receive different scores and will be ranked separately by the Funding Committee.

Summary

Applicant:

Application Type: ☐ New ☒ Renewal ☐ Renewal and Expansion ☐ Transition

Project Type: ☒ Permanent Supportive Housing ☐ Rapid Rehousing ☐ Transitional Housing ☐ Supporting Services Only (Stand Alone)
☐ Supportive Services Only – Coordinated Entry ☐ Supportive Services Only – Street Outreach ☐ HMIS ☐ CoC Planning

Name of Project in Good Grants: FY26-Journey Supportive Housing

Renewal Amount Requested: \$391,698.00

New/Expansion Amount Requested: \$0.00

Proposed # Households with Children Served: 0

Proposed # Households without Children Served: 30

Proposed % DV Households: 0%

Threshold Review – Staff Review (ALL PROJECT TYPES)

Category	Scoring Factors	Available	Received	Comments
Applicant Eligibility	Applicant must be one of the following to apply for CoC Program funding: state governments, county governments, city or town governments, special district governments, public and state controlled institutions of higher learning, Native American tribal governments (federally recognized), public housing authorities/Indian housing authorities, Native American tribal organizations (other than Federally recognized tribal governments), nonprofits having a 501(c)(3) status with the IRS, faith based organization. See page 9-10 of the HUD FY26 CoC Program Competition NOFO.	Pass/Fail	Pass	
Project Eligibility Threshold	See page 58 - 60 of HUD FY26 CoC Program Competition NOFO.	Pass/Fail	Pass	
Project Renewal Threshold	See page 61-62 of HUD FY26 CoC Program Competition NOFO.	Pass/Fail	Pass	
New Project Threshold	See page 62-69 of HUD FY26 CoC Program Competition NOFO.	Pass/Fail	N/A	
Reasonable Cost	Applicant demonstrated 'Reasonable Cost' in accordance with CFR 200.404 when affirming how projects meet quality thresholds (see description in Good Grants Project Thresholds Tab).	Pass/Fail	Pass	
Match	The recipient or subrecipient must match all grant funds, except for leasing funds, with no less than 25% of funds or in-kind contributions from other sources.	Pass/Fail	Pass	Proposed match is over what is needed

Project Review – Funding and Performance Committee Review

Category	Scoring Factors	Available	Project Type		Comments
			Renewal	New/ Expansion	
	HUD/CoC Priorities – ALL PROJECT TYPES				
Community Need <i>(General Narrative tab in Good Grants #2)</i>	2 points: Project meets or continues to meet a community need and/or fills a gap in FRCoC services. 1 point: Project somewhat meets a need and/or fills a gap. 0 points: Project does not meet a need and/or fill a gap.	2	2	N/A	
Leveraging Mainstream Resources <i>(General Narrative tab in Good Grants)</i>	2 points: Project fully leverages mainstream resources including employment, mental health, social security, TANF, etc. and demonstrates outcomes or improved processes as a result of these connections. 1 point: Project somewhat leverages mainstream resources. 0 points: Project does not leverage mainstream resources.	2	2	N/A	
Leveraging System Partnerships <i>(General Narrative tab in Good Grants #6)</i>	2 points: Project fully leverages partnerships within the homelessness response system to limit duplication. 1 point: Project somewhat leverages partnerships within the homelessness response system to limit duplication. 0 points: Project does not leverage partnerships within the homelessness response system to limit duplication.	2	2	N/A	
BONUS POINTS - Leveraging Healthcare Services <i>(General Narrative tab in Good Grants #7)</i>	1 point: Project has direct contributions from public and private health providers that value at least 25% of the funding requested.	1	0	N/A	Letters provided already matched in the Hesed House application
BONUS POINTS - Supportive Service Participation	1 Bonus point: Project requires participation in supportive services (e.g. case management, employment training, substance use disorder	3	1	N/A	Letters provided already matched in the Hesed House application

<i>(General Narrative tab in Good Grants #14) – up to 3 points available</i>	treatment - as documented in a supportive services agreement) to continue participation in the project 1 Bonus point: Project provides supportive services with a value of 50% their project request (documented in formal letters of support/agreements) 1 Bonus point: Project proposed using 30% their project request on supportive services				
BONUS POINTS - Treatment and Recovery Services <i>(General Narrative tab in Good Grants #15)</i>	1 Bonus Point: Project can demonstrate that substance use treatment is available on-site by listing the projects and treatment providers. 1 Bonus Point: Project can demonstrate that substance use treatment is required for participants who advise substance use.	2	1	N/A	
HUD/COC PRIORITIES TOTAL		12	8	N/A	
Project Performance and System Improvement (THIS SECTION IS NOT APPLICABLE FOR HMIS APPLICATIONS)					
Exits to Permanent Housing <i>(Project Performance tab in Good Grants #1)</i>	2 points: Percentage of exits to permanent housing is at least 50%. 1 point: Percentage of exits to permanent housing is 25% - 49% 0 points: Percentage of exits to permanent housing is less than 25%.	2	2	N/A	86% exits to permanent housing
Exits to Permanent Housing <i>(Project Performance tab in Good Grants #1a)</i>	2 points: Project demonstrates it has strategies in place that will ensure that at least 50% of participants exit to permanent housing and has the funding and partnerships to support the strategies.	2	2	N/A	
Jobs and Income Growth <i>(Project Performance tab in Good Grants #2)</i>	2 points: Percentage of participants that increased their employment income is at least 25% 1 point: Percentage of participants that increased their employment income is 13%-24% 0 points: Percentage of participants that increased their employment income is less than 13%	2	0	N/A	0% increase in earned income
Jobs and Income Growth <i>(Project Performance tab in Good Grants #2a)</i>	2 points: Project fully assists participants to increase their employment and/or income and to maximize their ability to live independently. 1 point: Project somewhat assists with employment/income and living independently.	2	2	N/A	

	0 points: Project does not assist with employment/income and living independently.				
Returns to Homelessness (Project Performance tab in Good Grants #3)	2 points: Less than 8% of participants returned to homelessness after program exit to permanent housing over 24 months. 1 point: Less than 16% returned to homelessness after program exit to permanent housing over 24 months.	2	0	N/A	50% returns
Returns to Homelessness (Project Performance tab in Good Grants #3a)	2 points: Thorough systems are in place to assist the CoC in reducing the number of returns to homelessness and has the funding and partnerships to support the strategies. 1 point: These systems are somewhat in place. 0 points: These systems are not in place.	2	2	N/A	
Reduce Length of Time Homeless (Project Performance tab in Good Grants #4)	2 points: Thorough systems are in place to assist the CoC in reducing the community's overall length of time homeless and has the funding and partnerships to support the strategies. 1 point: These systems are somewhat in place. 0 points: These systems are not in place.	2	1.4	N/A	
Reduction in First Time Homeless (Project Performance tab in Good Grants #5)	2 points: Thorough systems are in place to assist the CoC in reducing the community's overall first time homeless and has the funding and partnerships to support the strategies. 1 point: These systems are somewhat in place. 0 points: These systems are not in place.	2	1.2	N/A	
Cost Effectiveness (Project Performance tab in Good Grants #6)	2 points: At or below average for the region (\$5,000 for RRH; \$9,700 per year for PSH.) 1 point: Within 25% over the average for the region (above). 0 points: Over 25% higher than the average for the region. *FOR PERMANENT HOUSING PROJECT TYPES ONLY – NOT APPLICABLE FOR HMIS,TH, AND SSO PROJECT APPLICATIONS*	2	0	N/A	\$15,309 annually
Budget Appropriateness (Budget tab in Good Grants)	2 points: The project's budget provided sufficient detail and made sense given the project description and target population.	2	2	N/A	

	1 point: The project's budget left some question on spending and was somewhat out of sync with project description and target population. 0 points: The Budget was not clear, and was inappropriate for project description and target population.				
System Performance Improvement (Project Performance tab in Good Grants #2)	2 points: Project is a high performing project and will assist the CoC will improving overall system performance.	2	2	N/A	
PROJECT PERFORMANCE TOTAL		22	14.6	N/A	
Program Operations and Administration					
Organizational Capacity (General Narrative tab in Good Grants #9)	2 points: Organizational structure and capacity are sufficient to carry out proposed activities. 1 point: Organizational structure and capacity are somewhat sufficient to carry our proposed activities. 0 points: Organizational structure and capacity are not sufficient to carry out proposed activities.	2	2	N/A	
Staff Capacity (General Narrative tab in Good Grants #10)	2 points: Staff capacity is sufficient to carry out proposed activities. 1 point: Staff capacity is somewhat sufficient to carry out proposed activities. 0 points: Staff capacity is not sufficient to carry out proposed activities.	2	2	N/A	
Prior Experience (General Narrative tab in Good Grants #11)	2 points: Applicant/sub recipients have previous experience in effectively utilizing federal funds and performing proposed eligible activities AND serving proposed target population. 1 point: Applicant/sub recipients have experience with only one. 0 points: Applicant/sub recipients have experience with neither.	2	2	N/A	
Findings (General Narrative tab in Good Grants #12)	1 point: Applicant does not have any unresolved monitoring or audit findings or has an adequate plan to address issues. 0 points: Applicant does have unresolved monitoring or audit findings and does not have an adequate plan to address issues.	1	1	N/A	

Spending Rates (General Narrative tab in Good Grants #13)	DEDUCT 2 points for programs that DID NOT fully expend grant award for last full year of operation. DEDUCT 1 point for programs that DID NOT regularly draw down funds during grant award for last full year of operation.	0	0	N/A	
PROGRAM OPERATIONS AND ADMINISTRATION TOTAL		7	7	N/A	

Additional Comments

Changes Needed Before Collaborative Application Submitted (if any)

VA-514:
Fredericksburg Regional CoC
FY26 CoC Program Application

Attachment 1D-2c:
Local Competition Selection Results

VA-514 FY26 CoC Program Project Applications

Project Applicant	Project Name	New/Renewal	Project Type	Application Score	Project Status - Accepted, Reduced Reallocated, Fully Reallocated	Rank	Amount Requested From HUD	Reallocated Funds +/-
GWRC	FY26 CoC Program Competition HMIS Application	Renewal	HMIS	15/15	Accepted	1	\$ 62,947.00	\$ -
GWRC	FY26 CoC Program Competition HMIS Application	Expansion	HMIS	15/15	Accepted	4	\$ 57,487.00	\$ 45,228.00
Empowerhouse	Empowerhouse Domestic Violence PH-RRH transition to Transitional Housing FY26	Transition	Rapid Rehousing > Transitional Housing	26.6/33	Accepted	3	\$ 187,758.00	\$ 187,758.00
Empowerhouse	Empowerhouse Domestic Violence FY26 Transitional Housing	New	Transitional Housing	28/33	Accepted	6	\$ 172,438.00	\$ -
Loisann's Hope House	LHH - Family Shelter SSO	New	Support Serivces Only	24.5/30	Accepted	5	\$ 180,675.00	\$ -
Micah Ecumenical Ministries	FY26-Journey Supportive Housing	Renewal	PH-Permanent Supportive Housing	29.6/41	Accepted	2	\$ 391,698.00	\$ -
Micah Ecumenical Ministries	Hesed House	New	Transitional Housing	29.6/33	Accepted	7	\$ 307,066.00	\$ -
Empowerhouse	PH-RRH Domestic Violence FY24 and FY25	Renewal	Rapid Rehousing	Not Scored*	Fully Reallocated	N/A*	0.00**	\$ (187,758.00)
Empowerhouse	Empowerhouse Rural DVRRH 2022	Renewal	Rapid Rehousing	Not Scored*	Fully Reallocated	N/A*	0.00**	\$ (45,228.00)
GWRC	VA-514 CoC Planning FY26	N/A	CoC Planning	N/A	Accepted	N/A	\$50,000.00	\$ -

Notes:

* Projects identified as “Fully Reallocated” were eligible renewal projects for which the recipient elected not to submit a FY2026 renewal application. Because no project application was submitted for local review, these projects were not scored or ranked.

** “Amount Requested from HUD” reflects the amount requested through a FY2026 project application. Because no renewal application was submitted for these projects, the amount requested is \$0. The amount made available through voluntary reallocation is shown in the “Reallocated Funds +/-” column.

VA-514:
Fredericksburg Regional CoC
FY26 CoC Program Application

2A-8b:
FY 2026 HDX Competition Report

2026 HDX Competition Report

This workbook contains summary information about your CoC's data as it was entered into the HDX for your use as part of the 2026 Competition.

To Print this Workbook:

This document has been configured as printable with preset print areas of relevant sections. To print it, go to "File", then "Print", then select "Print Entire Workbook" or "Print Active Sheets" depending on your needs.

To Save This Workbook as a PDF:

Click the "File" Tab, then click "Save As" or "Save a Copy", then click "Browse" or "More Options" then select "PDF", click "Options", select "Entire Workbook", press "OK", and click "Save". These instructions may differ depending on your version of Microsoft Excel.

On Accessibility, Navigability, and Printability:

This workbook attempts to maximize accessibility, navigability, printability, and ease of use. Merged cells have been avoided. All tables and text boxes have been given names. Extraneous rows and columns outside printed ranges have been hidden.

For Questions:

If you have questions, please reach out to HUD via the "Ask a Question" page, <https://www.hudexchange.info/program-support/my-question/> and choose "HDX" as the topic.

2025 HDX Competition Report

2026 Competition Report - Summary

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

HDX Data Submission Participation Information

Government FY and HDX Module Abbreviation	Met Module Deadline*	Data From	Data Collection Period in HDX
2025 LSA	Yes	Government FY 2025 (10/1/24 - 9/30/25).	November 2025 to January 2026
2025 SPM	Yes	Government FY 2025 (10/1/24 - 9/30/25).**	February 2026 to March 2026
2026 HIC	Yes	Government FY 2026. Exact HIC and PIT dates vary by CoC. For most CoCs, it was within the last 10 days of January, 2026.	March 2026 to April 2026
2026 PIT	Yes	Government FY 2026. Exact HIC and PIT dates vary by CoC. For most CoCs, it was within the last 10 days of January, 2026.	March 2026 to April 2026

- 1) FY = Fiscal Year
- 2) *This considers all extensions where they were provided.
- 3) **"Met Deadline" in this context refers to FY25 SPM submissions. Resubmissions from FY24 (10/1/2023 - 9/30/2024) were also accepted during the data collection period, but the previous year's submission is voluntary.

2025 HDX Competition Report

2026 Competition Report - LSA Summary & Usability Status

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

LSA Usability Status 2025

Category	EST AO	EST AC	EST CO	RRH AO	RRH AC	RRH CO	PSH AO	PSH AC*	PSH CO
Fully Usable	☒	☒	☒	☒	☒	☒	☒	N/A	☒
Partially Usable								N/A	
Not Usable								N/A	

Glossary: EST = Emergency Shelter, Save Haven, & Transitional Housing; RRH = Rapid Re-housing; PSH = Permanent Supportive Housing; AO = Persons in Households without Children; AC = Persons in Households with at least one Adult and one Child; CO=Persons in Households with only Children
*Usability was not determined for PSH-AC due to built-in conflicts between HOMES and HMIS. As

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties 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	396	93.2	43.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	413	106.3	49.0

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.

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

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”)	460	437.7	315.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	466	462.9	324.0

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	37	4	10.8%	5	13.5%	6	16.2%	15	40.5%
Exit was from ES	95	3	3.2%	3	3.2%	6	6.3%	12	12.6%

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

Exit was from TH	45	0	0.0%	3	6.7%	1	2.2%	4	8.9%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	65	1	1.5%	3	4.6%	2	3.1%	6	9.2%
TOTAL Returns to Homelessness	242	8	3.3%	14	5.8%	15	6.2%	37	15.3%

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	421
Emergency Shelter Total	403
Safe Haven Total	0
Transitional Housing Total	39

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

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)	8
Number of adults with increased earned income	1
Percentage of adults who increased earned income	12.5%

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)	8
Number of adults with increased non-employment cash income	3
Percentage of adults who increased non-employment cash income	37.5%

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

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

Metric	Value
Universe: Number of adults (system stayers)	8
Number of adults with increased total income	4
Percentage of adults who increased total income	50.0%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	11
Number of adults who exited with increased earned income	0
Percentage of adults who increased earned income	0.0%

Metric 4.5 – Change in non-employment cash income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	11

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

Number of adults who exited with increased non-employment cash income	1
Percentage of adults who increased non-employment cash income	9.1%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	11
Number of adults who exited with increased total income	1
Percentage of adults who increased total income	9.1%

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
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2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

Universe: Person with entries into ES-EE, ES-NbN, SH or TH during the reporting period.	390
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.	91
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)	299

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.	450

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

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.	117
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.)	333

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
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2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

Universe: Persons who exit Street Outreach	203
Of persons above, those who exited to temporary & some institutional destinations	52
Of the persons above, those who exited to permanent housing destinations	57
% Successful exits	53.7%

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	371
Of the persons above, those who exited to permanent housing destinations	102

2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

% Successful exits	27.5%
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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	113
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	109
% Successful exits/retention	96.5%

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
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2025 HDX Competition Report

2026 Competition Report - SPM Data

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

Unduplicated Persons Served (HMIS)	428	39	126	219	218
Total Leavers (HMIS)	368	27	9	114	151
Destination of Don't Know, Refused, or Missing (HMIS)	147	2	0	0	26
Destination Error Rate (Calculated)	40.0%	7.4%	0.0%	0.0%	17.2%

2025 HDX Competition Report

2026 Competition Report - SPM Notes

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

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

Notes For Each SPM Measure

Measure		Notes
Measure 1	No notes.	
Measure 2	No notes.	
Measure 3	No notes.	
Measure 4	No notes.	
Measure 5	No notes.	
Measure 6	No Notes. Measure 6 was not applicable to CoCs in this reporting period.	
Measure 7	No notes.	
Data Quality	No notes.	

2026 Competition Report - HIC Summary
VA-514 - Fredericksburg/Spotsylvania, Stafford Counties 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 ¹ 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	Total Year-Round, Current, VSP Beds in an HMIS-Comparable Database	Total Year-Round, Current, VSP Beds	Removed From Denominator: OPH EHV ¹ Beds or Beds Affected by Natural Disaster**	Adjusted*** Total Year-Round Current, VSP Beds	HMIS Comparable Bed Coverage Rate for VSP 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	95	63	63	0	63	100.0%	32	32	0	32	100.00%	95	95	100.00%
SH	0	0	0	0	0	NA	0	0	0	0	NA	0	0	NA
TH	14	14	14	0	14	100.0%	0	0	0	0	NA	14	14	100.00%
RRH	107	63	63	0	63	100.0%	44	44	0	44	100.00%	107	107	100.00%
PSH	235	156	235	0	235	66.4%	0	0	0	0	NA	156	235	66.38%
OPH	0	0	0	0	0	NA	0	0	0	0	NA	0	0	NA
Total	451	296	375	0	375	78.9%	76	76	0	76	100.00%	372	451	82.48%

2026 Competition Report - HIC Summary

VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC

For HIC conducted in January/February of 2026

- 1) † EHV = Emergency Housing Voucher
- 2) *This column includes Current, Year-Round, Natural Disaster beds not associated with a VSP that are not HMIS-participating. For OPH Beds, this includes beds that are Current, Non-HMIS, and EHV-funded.
- 3) **This column includes Current, Year-Round, Natural Disaster beds associated with a VSP that are not HMIS-participating or HMIS-comparable database participating. For OPH Beds, this includes beds that are Current, VSP, Non-HMIS, and EHV-funded.
- 4) ***Adjusted bed counts exclude non-HMIS participating OPH EHV Beds and Beds Affected by Natural Disaster
- 5) Data included in these tables reflect what was entered into HDX 2.0.
- 6) In the HIC, "Year-Round Beds" is the sum of "Beds HH w/o Children", "Beds HH w/ Children", and "Beds HH w/ only Children". This does not include Overflow ("O/V Beds") or Seasonal Beds ("Total Seasonal Beds").
- 7) In the HIC, "Current" beds are beds with an "Inventory Type" of "C" and not beds that are Under Development ("Inventory Type" of "U").
- 8) For historical data: Aggregated data from CoCs that merged are not displayed if HIC data were created separately - that is, only data from the CoC into which the merge occurred are displayed. Additional reports can be requested via AAQ for any CoCs that have been subsumed into other CoCs.

2025 HDX Competition Report

2026 Competition Report - PIT Summary
VA-514 - Fredericksburg/Spotsylvania, Stafford Counties CoC
For PIT conducted in January/February of 2026

Submission Information

Date of PIT Count	Received HUD Waiver
1/28/2026	Not Applicable

Total Population PIT Count Data

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Emergency Shelter Total	187	159	157
Safe Haven Total	0	0	0
Transitional Housing Total	12	12	9
Total Sheltered Count	199	171	166
Total Unsheltered Count	14	18	12
Total Sheltered and Unsheltered Count*	213	189	178

1) *Data included in this table reflect what was entered into HDX 2.0. This may differ from what was included in federal reports if the PIT count type was sheltered only.
2) Aggregated data from CoCs that merged is not displayed if PIT data were entered separately - that is, only data from the CoC into which the merge occurred are displayed. Additional reports can be requested via AAQ for any CoCs that have been subsumed into other CoCs.

Total People Experiencing Chronic Homelessness

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Total Sheltered Count	20	27	29
Total Unsheltered Count	3	9	5
Total	23	36	34