

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: FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

1A-2. Collaborative Applicant Name: United Way of Suwannee Valley

1A-3. CoC Designation: CA

1A-4. HMIS Lead: United Way of Suwannee Valley

1B. Coordination and Engagement–Accountable Structure and Participation

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

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

1B-1.	Accountable Structure and Participation.	
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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	0
2.	CDBG/HOME/ESG Entitlement Jurisdiction(s)	Nonexistent	
3.	Certified Community Behavioral Health Clinic (CCBHC)	Yes	0
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)	No	
9.	Faith-based Organization(s)	Yes	0
10.	Homeless or Formerly Homeless Person(s)	Yes	1
11.	Hospital(s)	Yes	0
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	0
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Nonexistent	
14.	Law Enforcement	Yes	0
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	No	
16.	Local Government Staff/Official(s)	Yes	0

17.	State Government Staff/Official(s)	No	
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	0
24.	Other nonprofit homeless assistance provider(s)	Yes	1
25.	Other social service provider(s)	Yes	0
26.	Public Housing Agencies	No	
27.	Recovery Housing or Sober Living Provider(s)	Yes	0
28.	School Administrators/Homeless Liaison(s)	Yes	0
29.	School District(s)	Yes	1
30.	Street Outreach Team(s)	Yes	0
31.	Substance Abuse Advocate(s)	Yes	0
32.	Substance Abuse Service Organization(s)	Yes	0
33.	Universities	No	
34.	Veteran Serving Organization(s)	Yes	0
35.	Agencies Serving Survivors of Human Trafficking	Yes	0
36.	Victim Service Provider(s)	Yes	0
37.	Domestic Violence Advocate(s)	Yes	0
38.	Other Victim Service Organization(s)	Yes	0
39.	State Domestic Violence Coalition	Yes	0
40.	State Sexual Assault Coalition	Yes	0
41.	Youth Advocate(s)	Yes	0
42.	Youth Homeless Organization(s)	Yes	0
43.	Youth Service Provider(s)	Yes	1
44.	Other Homeless Assistance Provider(s)	Yes	0
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	1
	Other: (limit 50 characters)		
46.	Florida Legal Services	Yes	0
47.	Veteran Services	Yes	0

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 open invitation for new members includes a process for community members to attend any meeting at any time and to join the coalition at any time during the year. A membership drive is conducted annually to ensure participants renew their memberships and is free to join. The invitation includes a broad email distribution list of those who attend, have attended, or have asked to be included on the distribution list with meeting notices distributed to this list for all meetings. Participants are asked to invite additional participants several times throughout the year. Information regarding the coalition is shared at community events through a UW/homeless coalition display and at UW events with an invitation to participate to any interested individuals/entities. Information is included on the UWSV, lead agency, website. UWSV also posts meeting information on social media formats (Facebook, Instagram). Membership applications are available on our website throughout the year for any agency, community advocate or concerned citizen to apply and join. The CoC is able to effectively communicate with individuals with disabilities utilizing the Deaf & HardOfHearing Auxiliary process through DCF and have communication devices available if needed. UWSV office also provides ASL/LEP assistance through approved interpreters. Meetings can be accessed electronically by Teams with the meeting link widely distributed. Meeting materials are distributed electronically prior to the meeting. UWSV has linkages to communities experiencing homelessness in our geographic area and membership and personal invitations to join the coalition are extended. CoC members sit on other community agency meetings and boards that have similar interests and serve populations consistent with the CoC's priorities. We implemented a capacity building task within our agency that monitors community interests and targets agencies that have similar interests and investments in our community

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

(limit 2,500 characters)

CoC solicits & considers opinions from a broad array of organizations & indivs that have knowledge of homelessness or an interest in preventing & ending homelessness by distributing meeting notices to a broad list of those who attend/attended mtgs & others who have requested mtg notices. CoC posts the application in hopes to engage new agencies that have not previously received funding in the process giving those agencies opp to submit proposals. They may attend/provide opinions at mtgs. Participation open to any community indiv/entity. Participants & members encouraged to invite others. At the end of all coalition mtgs, there is an opp for public discussion related to homelessness. Public satisfaction surveys are posted on our website & also sent to clients for feedback. Conduct the PIT w/ surveys specifically related to homelessness. Street Cards distributed thru outreach w/ homeless & community members w/ contact info for various agencies to address homelessness. A Landlord Cmte convened to gather opinions & feedback about programs & how to better serve clients. Communicates info during public mtgs/forums the CoC uses to solicit public info thru notices to a broad distribution list, encourages participants to invite others. Street cards list assist agencies, homeless directories, 211 cards, & other flyers for assistance are disseminated at all mtgs & speaking engagements CoC members & staff participate in. UWSV joins civic opportunities & shares assistance available, funding opps & upcoming mtgs at events. The CoC is able to effectively communicate w/ individuals w/ disabilities utilizing the Deaf & HoH Aux process thru DCF & communication devices available if needed. UWSV also provides ASL/LEP assistance thru approved interpreters. Mtgs can be accessed by Teams w/ the mtg link widely distributed. Mtg materials sent electronically prior to the mtg. Takes into consideration info gathered in public mtgs/forums to address improvements or new approaches to preventing & ending homelessness by accepting, researching, securing approaches used by other CoC's thru consulting CoC's, CoC regional/statewide mtgs facilitated by mental health managing entity, requesting & attending HUD TA sessions, & training opps through Office on Homelessness, FCEH & FCH. Knowledge gained from these resources is added to policy/strategic plan to make sure homelessness is rare, brief & nonrecurring. The coalition has made available materials for distributing thru out the community

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)

CoC will consider applications from organizations that have not previously rcvd CoC program funding thru the distribution of the coalition HUD CoC application RFP to the broad email distribution list which includes all participants in the coalition, those who have attended coalition meetings & others who have requested to be included on the email distribution list and also posted on our website on June 16. It is suggested to post and share the RFP on agency websites. RFP specifically states any agency providing any svcs to any subpopulation of households either homeless/at risk should submit agency projects to the coalition's CoC Action Plan. All projects funded thru coalition-related state/federal funding/other resources, are incorporated into CoC Action Plan. RFP outlines eligibility & methods project proposals should be submitted thru specific directions & a project proposal form. Threshold requirements, detailed instructions, and specific forms are required for submission. The process the CoC uses to determine whether the project application will be included in the CoC Program Competition process is specified in the RFP. At a full CoC meeting, the CoC has Review Panel members, who don't have any conflict of interest w/ project/sponsor agencies submitting proposals. Staff completes threshold eligibility sheets for each proposal and gives that portion to the Review Panel. The Review Panel reviews the project proposals for eligibility, scores & rank projects according to CoC adopted P&P. SPM, spending, Housing 1st and equitable policies are reviewed and scored based on the written proposal information and makes a recommendation to the CoC. The CoC full membership votes on inclusion in the CoC , then will vote on the recommended scores from the Review Panel after the proposals have been submitted. The NOFO was posted on UWSV website again on June 16 with the scoring sheets and the scoring process protocol prior to the Review Panel meeting. The CoC is able to effectively communicate w/ individuals w/ disabilities utilizing the Deaf & HardOfHearing Auxiliary process thru DCF & have communication devices available if needed. UWSV office will provide ASL/LEP assistance thru interpreter. All documents are posted in PDF format on our website that comply with most accessible adaptive equipment.

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)

FL-518 plans comprehensive strategies for reducing homelessness by enhancing the programs already in place throughout the continuum. The CoC is committed to reduce homelessness based on guidance from HUD related to permanent supportive housing, rapid rehsg services and short-term flexible subsidies to overcome barriers to rehsg, with support services concentrating on improving incomes to pay rent, coupled w/performance measures to emphasize rapid and permanent hsg and leveraging funds from mainstream family service systems. 1. Coc identified gaps & data driven needs – 2026 PIT found 6% reported SMI & 3% reported SUD. Projects reallocation and new projects will provide TH beds w/supportive services for this unsheltered population. Stakeholder feedback from committee meetings highlight lack of requirement for supportive services as a restriction moving to stability for this population. 2. Strategies to address the needs of all relevant subpopulations – CoC reports while many of our unsheltered are single individuals and recognizing the rural capacity and lack of emergency shelter beds, new projects will focus on families and children and the elderly populations as they are proven to be more vulnerable unsheltered. Our current PSH beds are transitioning to TH to be able to provide services for individual homeless w/supportive service requirements for treatments for SUD/SMI. RR (family w/children) projects w/now include service requirements of case management, workforce development, childcare connections, healthcare, counseling to help promote self sufficiency. Each client requires a case plan review every 3 months to track progression and updates for income, education, behavioral health, healthcare services & substance use counseling/TX as needed. 3. Quantifiable Performance Measures – w/additional funding and beds and requirements for supportive services, the CoC plans to increase positive exits to more permanent hsg by 25% within 12 months, ensure at least 50% of participants in new TH projects achieve increase in mainstream benefits or employment income prior to exit. 4. Timelines – Q1grant execution & finalize intake processes Q2 CE referrals, begin intake, collect data Q3 50% capacity in programs Q4 full operational capacity, review data for performance review 5 Funding Sources – HUD CoC 2026 NOFO, other State and local funds for supports and match 6 UWSV, lead agency/HMIS lead/CA for HUD CoC grant has reports and process in place for monitoring

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

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

1C. Coordination and Engagement

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

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

	1C-1.	Treatment and Recovery Services—On-site Substance Use Treatment Availability.	
		You must upload the List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment attachment to the 4A. Attachments Screen.	
		What percent of your TH/RRH/PSH projects have substance use treatment available on site?	0%

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)

FL-518 CoC a HUD cert rural region works closely w/ Meridian Healthcare, the area's Certified Community Behavioral Health Clinic (CCBHC) & primary provider of mental health & substance use Tx. In 2025, Meridian provided more than 18,010 clients & provided more than 638,000 mental health, substance use disorder, crisis, Tx, recovery, & supportive svcs encounters across its regional svcs area. As a CCBHC, Meridian offers coordinated, evidence-based care regardless of a person's ability to pay & care is based on a person's needs. Substance use svcs include screening, comprehensive assessment, diagnosis, person-centered Tx planning, co-occurring out pt Tx, residential Tx, & Addictions Receiving Facility (ARF) svcs for crisis assessment, stabilization, & referral to continued care. Meridian also provides psych evaluation, medication mgmt, medication-assisted Tx, individual, group, & family counseling, crisis & mobile response, suicide prevention, post-crisis follow-up, peer recovery support, recovery navigation, & relapse-prevention svcs. People experiencing homelessness or housing instability can reach these svcs directly, through referrals from CoC providers & outreach teams, or through a warm h&off between the CoC & Meridian. Depending on the need, a person may be seen the same day or next day or may walk into a Meridian office. This partnership/pathway gives rural residents accessibility & opportunity to be provided assessment, Tx, care coordination, & recovery support. The CoC also coordinates w/ VOAF serving Veterans in the CoC & provides access to substance use Tx through the Lake City VA MC, including an Intensive Outpatient Program (IOP) & inpatient svcs for substance use & co-occurring mental health & substance use disorders. Individuals experiencing homelessness or housing instability may access Tx directly or through referrals from Coordinated Entry, outreach teams, housing/shelter providers, case managers, veteran-svcs providers, & CoC partners. CoC partners facilitate warm h&offs by helping participants contact providers, schedule svcs, address transportation or communication barriers, & coordinate housing & Tx needs. Depending on need, indivs may access walk-in, same-day or next-day svcs, crisis response, outpatient Tx, residential Tx, or other appropriate levels of care. This coordinated network expands access to assessment, Tx, crisis intervention, care coordination, & recovery supports for indivs experiencing homelessness thru the CoC's rural area

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)

Through its partnership with Meridian, the CoC can connect participants to mental health and substance use svcs that match the level of care needed. Outreach, case mgs, housing providers, & CE staff may identify need & make direct referral/warm handoff for screening, assessment, Dx, & Tx plan. Participants may need routine outpatient counseling or psych care, while others may need intensive outpatient svcs, Tx for co-occurring disorders, meds-assisted Tx, crisis stabilization, residential care, or inpatient Tx. Meridian & CoC communicate thru CoC mtgs & w/ CoC staff to stay informed when a participant moves from one level of care to another so that Tx, housing, & other care coordination & Tx supports remain connected. Available psychosocial svcs include indiv, group, & family counseling, motivational approaches, psychoeducation, skill building, relapse-prevention planning, & Tx for symptoms, substance use, trauma-related needs, & day-to-day functioning. Meridian also provides psychiatric evals, prescribing, meds education, monitoring for effectiveness & side effects, & follow-up when symptoms change or a participant has difficulty taking meds as directed. Meds-assisted Tx can be paired w/ counseling, care coordination, & recovery support. Suicide prevention is built into the system thru risk assessment, safety planning, mobile crisis response, stabilization, referral to a higher level of care when needed, & follow-up after a crisis. Peer svcs, recovery navigation, goal setting, relapse-prevention support, & community connections help participants continue moving forward. The CoC helps w/ some of the essential needs, while Meridian staff works w/ the CoC when housing instability is affecting Tx or recovery. CoC's housing prgms also support behavior health stability. Volunteers of America of Fla's LC PSH program has a Clinical Coordinator who provides mental health assessment & support, monitors participant needs, assists w/ crisis coordination, & coordinates behavioral health care & referrals as part of participants' ongoing Care Plans. When specialized or higher-level Tx is needed, participants are connected to community providers including Meridian & the Lake City VA MC for eligible veterans. Thru CE, outreach, housing providers, case mgt, & behavioral health partners, indivs are identified & connected to appropriate svcs. Partners use referrals, care coordination, warm handoffs to reduce barriers & help participants remain engaged in Tx & recovery supports

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)

CoC's partners w/Meridian gives participants access to peer recovery specialists & recovery supports thru Meridian's CCBHC services. Outreach, CE staff, housing case mgrs, & partner agencies recommend peer support for someone who is starting Tx, returning from a hospital/residential program, experiencing repeated crises, managing co-occurring conditions, & having trouble staying connected to care. W/ participant's consent, CoC staff do more than provide a phone #. They call Meridian w/ the participant, explain need, help schedule visit, resolve transportation/communication problems, & confirm the connection was made. Meridian's peer recovery specialists draw on both training & lived experience to build trust, reduce stigma, encourage hope, & help participants set their own recovery goals. Help someone prepare for an appt, stay engaged w/ counseling or meds svcs, adjust after a crisis/discharge, strengthen coping & self-advocacy skills, & connect w/ mutual-aid groups, recovery communities, wellness activities, & natural supports. Recovery navigation helps participants understand their options & move between assessment, outpt or residential Tx, meds-assisted Tx, psych care, crisis svcs, & f/u. Peers & navigators help address barriers, develop recovery plans, reconnect after missed appts, & coordinate benefits, transportation, primary care, employment, & community resources. At the same time, CoC assists w/ CE, housing refs, documentation, landlord/program communication, & other housing supports. Bc referrals processes are bi-directional, the CoC can request peer support when behavior health needs threaten hsg & Meridian can reconnect someone to the CoC when homelessness is putting recovery at risk. The CoC partner Volunteers of America of Fla (VOAF) recognizes the value of lived experience w/in housing svcs. VOAF has experience promoting former TH participants into Resident Manager positions w/ overnight program responsibilities. This approach brings firsthand understanding homelessness & transition toward stable housing into the prgm environment & provides participants w/ additional peer connection, encouragement, & practical support. Together, these provide access to formal peer recovery specialists & recovery navigation thru Meridian while incorporating lived-experience support w/in housing svcs. Peer support complements clinical Tx & case mgt by providing participants w/ relationships grounded in shared experience, recovery, & successful move toward stability

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)

CoC first become aware someone could have a serious mental illness thru street outreach, CE, a shelter or hsg provider, case mgt, or another contact in the homeless-response system. Staff look for concerns such as ongoing psych symptoms, difficulty functioning day to day, repeated crises or hospitalizations, frequent use of emergency svcs, trouble staying in Tx, or pattern of hsg loss tied to unmet behavior health needs. They consider what participant shares about past svcs, current risks, & barriers to hsg or daily functioning. CoC staff, w/ the participant's consent, connect the person to Meridian for a full clinical assessment, dx, & decision about the appropriate care. If the situation is urgent, they use the crisis system right away. A warm handoff include calling Meridian, help arrange the appt, sharing authorized information, address transportation/communication needs, & confirming referral received. If assessment shows a need for intensive community-based care, Meridian considers the person for its Florida Assertive Community Tx (FACT) Team or appropriate prgm. FACT is designed for people w/ serious/persistent mental illness w/ complex needs, repeated crises/hospital use, or difficulty succeeding in traditional office-based Tx. Its interdisciplinary team meets people in shelters, hsg, & community settings & may provide psych care, Tx planning, meds support, indvl & family interventions, crisis response, co-occurring substance use Tx, nsg & health coord, rehab, daily living skills, benefits assistance, peer support, & recovery-focused care coordination. Contact is based on person's needs & can change as symptoms & functioning change. CoC continues helping w/ hsg, benefits, docs, transport, & other needs. CoC partner Volunteers of America of Fla (VOAF) recognizes value of lived experience w/in hsg svcs. VOAF has experience promoting former TH participants into Resident Manager positions with overnight program responsibilities. This approach brings firsthand understanding of homelessness & the transition toward stable hsg into the prgm environment & provides participants w/ additional peer connection, encouragement, practical support. These approaches provide access to formal peer recovery specialists/recovery navigation thru Meridian while incorporating lived-experience support w/in hsg svcs. Peer support complements clinical Tx & case mgt by providing participants w/ relationships grounded in shared exp, recovery & success move toward great 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)

FL-518 CoC partners with Meridian Healthcare, the region's CCBHC, to serve individuals with mental health and substance use disorders involved with Mental Health Court and other specialty-court or forensic systems. Through its Forensic Multidisciplinary Team (FMT), Meridian coordinates behavioral health services and supports individuals under Assisted Outpatient Treatment (AOT) and those transitioning from inpatient civil commitment.

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)

FL-518 CoC coordinates with Meridian Healthcare to align behavioral health treatment, applicable court requirements, and housing supports. Meridian's Forensic Multidisciplinary Team (FMT), Mental Health Court relationships, and clinical programs address psychiatric symptoms, substance use, medication needs, crisis risk, functioning, and treatment engagement, while CoC providers focus on the steps necessary to obtain and maintain housing.

CoC providers assist with identification and benefits, housing applications and placement, transportation, landlord or program concerns, healthcare, food, income, employment, and other supports. With participant consent and within confidentiality requirements, coordination helps ensure that treatment, court expectations, and housing goals support rather than conflict with one another. When legally authorized and clinically appropriate, Mental Health Court or Assisted Outpatient Treatment (AOT) orders can provide additional structure around assessment, treatment participation, medication follow-up, substance use services, court reviews, and communication with designated providers. Meridian incorporates applicable requirements into the participant's clinical plan and monitors progress and barriers, while CoC providers assist with attendance, transportation, documentation, housing tasks, and other needs that could interfere with successful participation.

The coordinated team also monitors issues that could jeopardize housing, including worsening symptoms, missed treatment or medication, renewed substance use, loss of income or benefits, difficulty with daily living skills, or lease-related concerns. Meridian can increase community-based treatment, medication support, counseling, peer services, crisis prevention, or rehabilitation, while CoC providers can increase tenancy coaching, housing problem-solving, and practical support.

When setbacks occur, Meridian and CoC providers use outreach, case conferencing, additional care coordination or treatment supports, and reassessment to reconnect the participant before the situation results in eviction, rearrest, or another crisis. This coordination uses court involvement, when applicable, to reinforce treatment engagement and accountability while supporting housing stability and movement 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)

FL-518 CoC partners with Meridian Healthcare to connect individuals experiencing homelessness with the local crisis system of care, including 988 and crisis contact centers, Meridian's Mobile Response Team (MRT), crisis receiving and stabilization services, and post-crisis follow-up. MRT provides community-based crisis response and can connect individuals to stabilization, emergency, inpatient, or other appropriate care when needed

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.	36

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)

FL-518 CoC has a formal partnership with Meridian Healthcare, the area's Certified Community Behavioral Health Clinic (CCBHC) and a SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider. Meridian participates in CoC planning and referral coordination and connects individuals experiencing homelessness with behavioral health assessment, treatment, crisis care, peer and recovery support, and care coordination

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

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

(limit 500 characters)

The CoC has Sober Housing options available, including those associated with HUD CoC funded agencies, VOA (PSH/TH) & UWSV (RRH). The CoC has three faith based Sober Housing projects, all funded privately. Referrals are made and formal MOUs are in place. Once a participant of the Sober Housing units is ready for housing placement, referrals & screenings are completed, eligibility determined and placement on CE for housing placement. Case management requirement begins with initial referral.

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)

CoC works w/Meridian's CCBHC, outpt & substance use prgms, peer & recovery-navigation svcs, FACT Team, FMT & Mental Health Court partners, 988-connected crisis svcs & MRT, PATH, & TIEH to make sure hsg referral leads to real connection. Staff across these prgms ask about where person is staying, whether eviction/discharge is likely, rent/utility arrears, safety, income/benefits, identification, transport, & other issues that could lead to homelessness. CoC partners also identify behavior health, substance use, crisis, forensic, & recovery needs require Meridian's help. W/ participant's consent & w/in privacy requirements, warm handoff may involve calling CE or hsg provider while participant is present, explaining immediate circumstances, sharing available documents, arranging assessment/intake, making clear who will take next step. CoC staff help complete hsg assessments, gather eligibility/income records, submit apps, locate an appropriate hsg option, & arrange emergency shelter or another safe interim setting when necessary. Meridian stays involved until referral is confirmed & helps address barriers such as transportation, lack of telephone access, symptoms, cognitive limitations, or difficulty w/ paperwork. Depending on eligibility & availability, CoC may connect a participant to homelessness-prevention assistance, rapid rehsg, permanent supportive hsg, subsidized or affordable hsg, landlord support, tenancy svcs, or other community resources. Meridian provides authorized clinical information needed for planning, while CoC & hsg provider make hsg eligibility & placement decisions. Tx & hsg assistance can move forward at same time. Prevention work may begin while someone is still housed if rent arrears, lease concerns, hospitalization, incarceration, worsening symptoms, meds interruption, renewed substance use, lost benefits, or difficulty functioning creates a risk of displacement. Meridian addresses clinical & recovery concerns, while CoC works on hsg, benefits, tenancy support, & prevention resources. When authorized, court partners may reinforce Tx, review, discharge, & communication requirements so a setback does not turn into eviction, incarceration, hospitalization, or homelessness. Before release or discharge from a hospital, crisis or residential prgm, jail, court prgm, shelter, or other setting, Meridian & CoC can work to confirm hsg when possible & arrange transportation, meds, follow-up care, benefits, identification, & contact information

1C-2. Supportive Services Investment.

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$442,690
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.	\$647,579
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	146%
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.	\$21,612
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).	151%

1C-3.

Participation Requirements for Supportive Services.

You must upload the Language from Project Supportive Service Agreements attachment to the 4A. Attachments Screen.

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

100.00%

1C-4. Consulting with ESG Recipients.

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

(limit 2,500 characters)

The CoC actively collaborates with the State of FL Office on Homelessness, which serves as the direct recipient of HUD ESG. UWSV, Lead Agency, has successfully applied for and received ESG funding for several years. FL-518 aligns with the State CoC Plan for regular consultation of planning, allocation and evaluations. The CoC refers to ESG regulations to distribute allocations of Street Outreach, ESG, Homeless Prevention, Rapid Rehousing & HMIS as data dictates the needs for our community. Comprehensive HMIS data including performance measures, PIT and HIC are monitored to ensure resource allocation is addressed to help close the gaps in our CoC. UWSV, Lead Agency/HMIS Lead for the rural CoC releases a competitive RFP in our community for agencies to apply for ESG funds with eligibility thresholds and metrics required by HUD ESG regulations. The COC will continue to collaborate with the State ESG and community partners to create, update and refine written standards for ESG funds aligned with the Coordinated Entry System and HMIS Policy and Procedures currently in place to ensure resources from the CoC and ESG are targeted to the most vulnerable individuals and families in our rural CoC.

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)

An open line of communication has been established in hand with a memorandum of understanding of which is agreed and acted upon with our shelter providers. The shelter providers maintain membership and ongoing participation in the CoC and share and receive information about resources and programs to assist persons who are homeless or at risk of homelessness. Shelter Providers exchange client-related information with appropriate authorization, in order to ensure client/client family services, and refer clients to UWSV who are at risk of homelessness or literally homeless to the UWSV coordinate entry coordinator. In addition, our outreach persons visit our shelter providers to ensure proper training of HMIS, lived experience interviews and case management triage for CoC assistance.

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)

We have shared data with government partners to help inform planning, policy development, and service delivery within the homelessness response system. This has included providing aggregated data on homelessness trends, demographic characteristics, service demand, housing outcomes, and gaps in support. By contributing data and analysis, we have helped governments better understand community needs, allocate resources, evaluate program effectiveness, identify emerging trends, and coordinate responses across housing, health, and social service sectors. Our local government frequently requests and receives data such as homelessness enumeration and point-in-time count results, geographic trends, data dashboards and performance reports, etc

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)

In addition to HMIS data, we leverage a variety of data sources to develop a more comprehensive understanding of individual and system needs. These sources include health care utilization data, behavioral health records, justice system data, school district and youth services data, workforce and income data, housing authority information, United Way ALICE data, and community-based service provider data. Integrating these datasets helps identify individuals at greatest risk, improve care coordination, address service gaps, monitor outcomes, and support more person-centered interventions.

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 has an active MOU with CareerSource North Florida. This allows the workforce agency to refer homeless or those at risk for assistance through CE. Case managers also refer clients in need to workforce boards, Voc Rehab, Employ U and adult education programs to help secure employment or increase skills for other employment opportunities. CareerSource is a member of our homeless coalition and shares information about services. The agency has been an agency spotlight for full membership meetings. Case managers follow up with clients and track progress. Case managers help clients build resumes through programs offered with the workforce agencies. Case managers work with local GoodWill stores to help clients obtain appropriate clothing to be able to "Dress for Success" for interviews. We have a dedicated case manager that research, collects and distributes local job available opportunities in our CoC and shares with case managers and clients. We receive "HotJobs" from CareerSource each week to distribute to clients and case managers. United Way of Suwannee Valley also maintains an ongoing partnership with CareerSource to support outreach and engagement opportunities for Veterans throughout the service area. Approximately once each month, the organizations collaborate to host a "Coffee with a Veteran" meeting at various community locations. These gatherings provide an accessible setting for Veterans to connect with service providers, learn about available employment and supportive services, and receive information and referrals to resources that may assist in addressing their individual needs. By bringing services directly into communities throughout the service area, this partnership helps strengthen outreach and improve Veterans' access to available resources

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 projects work closely with first responders, community paramedics, local police, and the Sheriff's Departments to create positive interactions with individuals experiencing homelessness. Outreach teams and first responders coordinate efforts to identify individuals in need, assess immediate safety and healthcare needs, and connect them with appropriate services.

Through this collaborative approach, outreach staff can respond alongside or following law enforcement and first responders when appropriate, allowing individuals to build trust with service providers while addressing public safety concerns. Individuals are connected to Coordinated Entry, emergency shelter, behavioral health and substance-use services, medical care, and transitional housing resources.

The CoC maintains clear roles between public safety and service providers. Law enforcement addresses immediate safety concerns and criminal activity, while outreach staff focus on engagement, housing navigation, and supportive services. Regular communication and referrals between agencies help reduce repeated contacts and increase successful engagement with CoC services. This coordinated co-response model promotes respectful interactions, improves access to services, and creates additional opportunities for individuals experiencing homelessness to transition from street homelessness to appropriate services, shelter, and 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)

The rural CoC has partnerships with family and support network agencies that assist with reunification. The CoC received a State Challenge Grant for Reunification efforts in 2024 which allowed partnerships to be made with Partnership for Strong Families (PSF) which is the lead community-based care agency for Florida Judicial Circuits 3 and 8. PSF is contracted by the Florida Department of Children and Families (DCF) to deliver comprehensive child welfare services to children who are victims of abuse and neglect. PSF also works with at-risk families to prevent child abuse and to decrease the risk of children entering the out-of-home care system. PSF serves nearly 5,000 children in 13 counties annually, including our CoC catchment area. This partnership enhanced our active connections with Gradian ad Litem, Regional Counsel Office of Criminal Conflict and Civil Regional Counsel, Camelot Community Care, Children's Home Society, the Family Intensive Treatment and Mother's Intensive Support Treatment programs which serve clients within our rural geographical area. Referrals are made to CE and assigned a case manager. Case managers make contact with the client and the referring case manager so our case managers can align with the case plan of the referring agency as to not overwhelm the client in an already challenging situation. Case management assesses the relationships and safety by building strategies with support networks that will promote growth, health, stability and self-sufficiency for the parent. Connections with counseling, treatment, recovery, education, employment, healthcare agencies or arrangements for relocation if needed to obtain and achieve client goals for stability are made. Case managers make sure client is evaluated for and applications are made for mainstream benefit opportunities available for each situation. Client is required to apply for SNAP, Medicaid, job training/opportunities and treatment/counseling for behavior health and/or substance treatments. Case plans are updated every 90 days, and weekly contact is required for continued assistance for reunification. Formal MOUs are in place.

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 partners with local law enforcement and first responders to enhance public safety while connecting individuals experiencing homelessness to housing and supportive services. Through coordinated outreach and participation in CoC planning, public safety agencies and service providers maintain a unified approach to community crisis response.

The CoC respects the jurisdiction and operational responsibilities of public safety agencies. CoC staff and providers remain focused on housing navigation, healthcare, and social services without interfering with law enforcement or emergency operations.

A direct referral pathway connects first responders to the CoC's Coordinated Entry System and vetted diversion resources, enabling individuals to quickly access shelter, behavioral health support, and other services while allowing first responders to return to active duty efficiently.

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)

Florida Statute 125.0231 governs public camping and public sleeping. It states that unless a County establishes a public space to be used for public camping or sleeping, that the applicable jurisdiction will not authorize any individual to engage in public sleeping or public camping. When referencing the public locations, the statute reads any public building or its grounds and any public right of way. This statute does not establish a punishment for private citizens that do not comply with the statute. Instead it directs the municipality or county to enforce the statute, in failing to do so, the statute states that any business owner, resident, or the Attorney General may bring a civil lawsuit against the body that failed to enforce the statute. It also states that if the lawsuit prevails the jurisdiction may be liable for court costs, reasonable attorney fees, investigative costs, witness fees, and depositions costs. In 1976 The Florida Supreme Court reviewed the decision in Corn vs State. It established in its ruling that in Florida the government has the same right as a private owner to manage and control property under its custody. A public space is only "open to the public" for its designated purpose and during its operational hours. Corn was convicted of trespassing, and it was later upheld by the Florida Supreme Court. In order for a municipality to enforce 125.0231, the must rely on existing criminal laws or established ordinances to enforce it. Specifically, trespassing can be enforced in public settings when a subject violates posted hours or closings, or enters restricted access areas contained within secured fencing, locked doors, etc, or another articulable fact can be presented that the offender is impeding public access to the locations (blocking sidewalks, access to buildings). If another crime is being committed then removal and arrest are applicable if probable cause and presence in front of an officer are present.

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)

There are various homeless encampments scattered throughout our rural areas. A lot of them move between private properties inside the jurisdiction. The encampments are disbanded when a property owner requests that they be removed. Occasionally a tent will be present on the property of a business and will be removed at the request of owner or management. These encampments are usually situated deep inside wooded areas that are not immediately visible to patrolling officers unless they are made aware of their presence.

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 use of illicit public drug use is on the rise. The local Police Departments utilizes proactive patrol and public tips to identify and combat drug use within its jurisdictional boundaries. Anonymous tips are of particular value for combating increasing instances of drug use in a public setting. Proper investigation is integral to identifying and seizing substances that pose a public safety risk. The Police Departments have recently reduced arrests for marijuana in amounts that are not distributable, making concentration on drugs that pose a greater public safety risk a possibility.

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

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

(limit 2,500 characters)

The Departments have seen an uptick on overdose cases since the introduction of fentanyl. Drugs that are considered less harmful are now being sold, laced with substances like fentanyl. These powerful chemicals often are not perceptible to the person with a belief that they are using a less potent substance. Accidental overdoses have substantially increased in the last few years as a result. The goal of an overdose response is immediate medical attention and less focused on enforcement per Florida Statute. Public drug use not involved in overdose situations has remained consistent and strict enforcement is the preferred method unless it pertains to personal use marijuana

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)

Involuntary examination, under the provisions of the Baker Act, is the primary response for subjects that pose a great risk to themselves or others. Particular attention is provided to homeless subjects who are often overlooked for mental health crisis. Mental health issues that do not pose a risk to self or others are referred to mental health professionals in the area without providing a preferred source. Immediate needs are addressed in a timely basis with the safety of the public and subject suffering the mental health crisis put as a priority.

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 works with local law enforcement and community service providers to ensure that information regarding registered sexual offenders is handled and shared in accordance with federal SORNA requirements and Florida law. Florida Statutes 943.043 and 943.0435 establish registration and public-notification requirements and require information regarding registered sexual offenders, including permanent, temporary, and transient residence information, to be reported to law enforcement and maintained by the Florida Department of Law Enforcement.

These requirements support the CoC's ability to protect public safety and appropriately coordinate housing and services. Florida law specifically addresses transient registrants, requiring them to report their location to the sheriff's office and update that information regularly. FDLE also shares information with local law enforcement to assist in locating individuals who fail to comply with registration requirements.

The CoC will leverage these existing systems by maintaining established communication with law enforcement and ensuring that participating housing and service providers understand their responsibilities regarding information sharing, confidentiality, and public records. When an individual is subject to registration requirements, providers will coordinate with the appropriate law-enforcement agency rather than attempting to independently verify or manage registry information.

The CoC will provide staff and provider training on SORNA-related responsibilities, establish clear referral and communication procedures, and encourage timely coordination with law enforcement when location or registration information is relevant to public safety. This approach allows the CoC to support housing stability and service access while maintaining compliance with federal and Florida requirements and protecting the safety of the community.

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)

Our outreach strategy is centered on proactive engagement, relationship building, and coordinated service delivery to connect individuals experiencing homelessness with housing and supportive services. Outreach staff regularly engage people in encampments, public spaces, and other locations where unsheltered individuals may reside. The goal is to establish trust, assess immediate needs, and facilitate access to resources that promote housing stability and overall well-being. Outreach staff recognize that each individual's circumstances, experiences, and needs are unique. Services include crisis intervention, housing navigation, coordinated entry assessments, assistance obtaining identification and benefits, referrals to healthcare and behavioral health services, and ongoing case management support.

Our outreach efforts are strengthened through collaboration with community partners, including healthcare providers, behavioral health agencies, first responders, veteran service organizations, faith-based groups, local governments, and other social service providers. Through coordinated outreach and information sharing, we work to identify vulnerable individuals, reduce barriers to services, and ensure timely connections to appropriate resources.

We prioritize individuals with the highest levels of vulnerability, including those experiencing chronic homelessness, serious mental illness, substance use disorders, disabling conditions, and frequent interactions with crisis systems. By combining field outreach, data-informed decision-making, and cross-sector collaboration, we strive to move individuals from homelessness to safe, stable, and permanent housing while supporting long-term self-sufficiency and improved quality of life.

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

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

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

1.	McKinney-Vento Liaison(s) (including State Education Agency (SEA) or Local Education Agency (LEA))	Yes
2.	School District(s)	Yes
3.	General Education Development (GED) Program(s)	Yes
4.	Community College(s)	Yes
5.	Technical College(s)	Yes
6.	Other Post-Secondary Education Provider(s)	Yes

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

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

(limit 2,500 characters)

McKinney-Vento State Education Agency (SEA) or Local Education Agency (LEA) relationship with the CoC results from coalition Policies and Procedures specifying the CoC collaborates with the LEAs to assist in the identification of homeless students and informs them of their eligibility for McKinney-Vento services. The Policies and Procedures also specify with a MOU, the LEAs actively participate in the CoC; provide annual training including the referral process, eligibility requirements and services; and assist families referred by agencies to access services to remove barriers to educational attendance and success. CoC agencies are expected to post materials, posters and brochures and refer families with school age children to the LEAs. The homeless liaison for the school districts participates and are members of the CoC homeless coalition. Columbia County homeless liaison is a member of the coalition and also on the board, Review Panel and other ad hoc committees as needed. They also have access to HMIS to help coordinate and share information with case managers and other CoC agencies. All four school districts in our CoC participate in coalition meetings and are invited to attend Coordinated Entry Case Conferencing monthly meetings.

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)

We work collaboratively with foster care agencies, child welfare providers, and youth-serving organizations such as the Guardian ad Litem program to support young people transitioning out of foster care and reduce their risk of homelessness. When youth enter our coordinated entry system, we provide referrals and case management, to help ensure youth have access to stable housing, supportive services, education, employment resources, and connections to caring adults as they move toward independence. We also connect transitioning youth to rapid rehousing programs, supportive housing opportunities, financial assistance, mentoring programs, and community resources designed specifically for young adults.

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

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

(limit 2,500 characters)

The CoC coordinates with local RHY funded providers through a mix of direct collaborations, community outreach and other agency resources. One RHY funded agency, CDS and Behavioral Health, participates in forums to promote services for runaway and homeless youth and shares the information and education presentations about resources available. The CoC actively builds relationships to distribute the information provided. CDS proactively seeks new promotion opportunities and engages in activities that expand resources for youth, including local street outreach programs. Department of Children and Families partners with the RHY for transitional living programs for placement and services for this vulnerable population. Services for pregnant teens and parenting youth are coordinated and funded through outside sources and available when needed. CDS participates in the homeless coalition and is a member of the Board and many ad hoc committees.

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)

United Way of Suwannee Valley receives HUD RRH specific to families w/ children experiencing homelessness. This prgm requires one child in the hh to be eligible for assistance. Housing assistance is provided in the form of rent, rental/utility deposits. Families are encouraged to work w/ local WorkforceBoards to increase income, job training/referrals to apprentice prgms. Case managers make sure families are receiving childcare, parenting classes, connections to education & mainstream benefits.

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)

United Way of Suwannee Valley receives HUD RR specific to families with children experiencing homelessness in our four-county HUD certified rural CoC. This program requires one child in the household to be eligible for assistance. Housing assistance is provided in the form of rent, rental deposits and utility deposits. Families are encouraged to work with local Workforce Boards to increase income, job training or referrals to apprentice programs. Case managers make sure families are receiving childcare, parenting classes, connections to education. The CoC has an active MOU with CareerSource North Florida. Case managers also refer clients in need to workforce boards, Voc Rehab, Employ U and adult education programs to help secure employment or increase skills for other employment opportunities. CareerSource is a member of our homeless coalition and shares information about services. The agency has been an agency spotlight for full membership meetings. Case managers follow up with clients and track progress. Case managers help clients build resumes through programs offered with the workforce agencies. Case managers work with local GoodWill stores to help clients obtain appropriate clothing to be able to "Dress for Success" for interviews. Case managers help prepare clients for possible interview situations in order for the client to gain employment. Weekly case management is a requirement of services and case plans are tracked and updated every 90 days for progress.

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)

United Way of Suwannee Valley receives HUD Rapid Rehousing specific to families with children experiencing homelessness in our four-county HUD certified rural CoC. This program requires one child in the household to be eligible for assistance. Housing assistance is provided in the form of rent, rental deposits and utility deposits. UWSV realizes housing is not just assisting with rent and utilities and work on linkages is made with initial contact. During intake, case managers interview the client household to gain knowledge and make an inventory of benefits already received and what benefits needed to help obtain self-sufficiency. There are three pillars needed to help make housing long term for the families. 1. Economic stability – families are connected with TANF cash assistance, employment programs, education, adult education and literacy programs, skillset review/reskilling programs, VOC rehab, SNAP benefits, food pantries, LIHEAP assistance, programs offered through FPL and other utility options. Budgeting classes are monthly to teach the basics of managing a household 2. Childcare and Parenting Supports – connections to subsidies for childcare through Early Learning Coalition, Suwannee Valley Community Coordinated Child Care for child education & parenting classes, Pregnancy Care Center for parenting classes, enrollments in evidenced-based home visiting programs (Nurse-Family Partnerships, Healthy Start) to teach positive parenting techniques, stress management and child development milestones, Women, Infant and Children benefits and 3. Health care – connections to Florida Department of Children and Families Medicaid, Healthy Kids, Sunshine, Healthy Start/HealthyMoms, pregnancy related care and post partum care, CHIP programs for well care checkups, immunizations, vision/dental care and early development screenings through the local health department. Most of these programs can be accessed through the Florida portal ACCESS Florida, which UWSV is a community partner with and applications and enrollments can be made inhouse. Follow up is made to make sure progress is made. Each case plan is on a case by case basis and other linkages can be made if needed (mental health services, substance use treatments, legal assistance). Case management is required weekly and case plans are updated every 90 days to remain in the program

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)

UWSV receives the HUD RR CoC funding for families with children in our 4 county rural certified HUD CoC. UWSV realizes housing is not just assisting with rent and utilities and work on linkages is made with initial contact. During intake, case managers interview the client household to gain knowledge and make an inventory of benefits already received and what benefits needed to help obtain self sufficiency. Focus is on (a) Childcare and Parenting Supports – connections to subsidies for childcare through Early Learning Coalition, Suwannee Valley Community Coordinated Child Care for child education & parenting classes, Pregnancy Care Center for parenting classes, enrollments in evidenced-based home visiting programs (Nurse-Family Partnerships, Healthy Start) to teach positive parenting techniques, stress management and child development milestones, Women, Infant and Children benefits and (b) Health care/Pregnancy related care – connections to Florida Department of Children and Families Medicaid, Healthy Kids, Sunshine, Healthy Start/HealthyMoms, pregnancy related care and post partum care, CHiP programs for well care checkups, immunizations, vision/dental care and early development screenings through the local health department. Most of these programs can be accessed through the Florida portal ACCESS Florida, which UWSV is a community partner with and applications and enrollments can be made inhouse. One local partnership is with NorthStar Family Resource Center. They provide after school child assistance, and schedules the UF Health OB/GYN Mobile Outreach bus twice a month for free ultrasound exams, family planning, breast feeding support and prenatal/postpartum care. Referrals are made to Pregnancy Care Center for parenting classes, baby care and prenatal and post partum care which includes education classes, stress management and counseling services. Clients are required to take classes in order to earn "Mommy Dollars" and "Daddy Bucks" to get baby supplies such as diapers, diaper wipes, clothes, furniture, etc. Follow up is made to make sure progress is made. Each case plan is on a case by case basis and other linkages can be made if needed (mental health services, substance use treatments, legal assistance). Case management is required weekly and case plans are updated every 90 days to remain in the program.

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)

Each Monday, United Way's Mission United program visits the American Legion to connect veterans and their families with critical community resources and support services. Our primary focus is promoting access to housing & utility assistance, helping veterans who may be experiencing financial hardship, housing instability, or challenges maintaining essential household services. This face-to-face outreach provides veterans with an accessible opportunity to learn about 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 rural FL-518 CoC partners w/ Another Way, Inc., a certified domestic violence center and rape crisis center serving seven North Florida counties, provides emergency shelter, a 24-hour helpline, safety planning, advocacy, counseling, housing navigation, and assistance connecting survivors with community resources, & Vivid Visions, Inc., a domestic violence shelter offering women/children safe shelter, hsg, supportive svcs, trauma resources necessary to establish long-term safety & stability.

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 rural CoC has formal agreement w/ local law enforcement to refer clients experiencing homelessness to United Way Suwannee Valley for services available for any program eligibility, including housing services for those released from jail/prison. Local law enforcement is a member of the homeless coalition & presents trainings as requested on local law and programs available and also partners with the Office of Criminal Conflict & Civil Regional Counsel court ordered programs

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 rural CoC partners with the LSF, the ME to identify high utilizers of the healthcare and homeless system to help refer those high utilizers to the appropriate PSH program and coordinate treatments and wraparound care for those with acute mental health issues and/or substance use to prevent costly hospitalizations. This type of intervention helped Florida decrease local emergency response expenses by 30%.

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)

UWSV, Lead Agency, utilizes State funds to connect with Adult Protective Services when an elderly/aging client is identified to ensure supportive services are utilized quickly and effectively. This partnership helps coordinate case management, CoC funded PSH programs, Medicaid waiver enrollment, and connect elderly experiencing homelessness w/ ALF, long term care providers if needed. Paramedicine programs are activated immediately if elderly client needs care. MOU in place

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)

Volunteers of America of Florida (VOAF) – Lake City Permanent Supportive Housing (PSH) Renewal Project. The project provides 11 Permanent Supportive Housing beds for single adults with disabilities experiencing homelessness and accepts referrals through the FL-518 Coordinated Entry system. The project prioritizes eligible individuals experiencing chronic homelessness for available PSH units, consistent with HUD and Continuum of Care prioritization requirements.

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)

Volunteers of America of Florida's Lake City Permanent Supportive Housing (PSH) project provides on-site behavioral healthcare support through an interdisciplinary team that includes a Program Manager, Independent Living Coach (ILC), and a Licensed Clinical Social Worker (LCSW) or Licensed Mental Health Counselor (LMHC). On-site behavioral healthcare includes clinical assessment, clinical consultation, ongoing monitoring of behavioral health needs, crisis coordination, behavioral health care coordination, and integration of identified behavioral health needs into each participant's Care Plan. The licensed clinician provides clinical oversight, consultation, and supervision for participants with significant mental health, substance use, and other clinical needs.

Upon enrollment, participants receive a comprehensive clinical assessment to identify behavioral health, functional, healthcare, and other needs that may affect housing stability and overall well-being. Assessment findings are incorporated into each participant's individualized Care Plan and are used to determine the appropriate frequency and intensity of services. Participants receive ongoing case management and monitoring, with contact occurring at least monthly and increasing to weekly or more frequently based on assessed need.

VOAF's clinical staff monitor changes in participant functioning and behavioral health needs, provide clinical consultation and crisis coordination, and facilitate connections to appropriate community-based behavioral health and substance use treatment providers. When treatment or specialized behavioral healthcare is required, VOAF coordinates referrals and continuity of care with community providers, including Meridian Behavioral Healthcare, the Lake City VA Medical Center, HCA Florida Lake City Hospital, and other behavioral health, healthcare, and substance use treatment resources.

This integrated model allows behavioral health needs to be identified and addressed within the participant's housing environment while connecting participants to the appropriate level of community-based treatment, helping reduce barriers to care and supporting long-term housing stability, wellness, and recovery.

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)

Volunteers of America of Florida (VOAF) maintains a policy for assessing whether Permanent Supportive Housing participants can remain safely and successfully in their current program setting or require a higher level of care. When behavioral health, substance use, medical, cognitive, functional, or safety needs may exceed the services available within PSH, staff initiate an assessment to identify the least restrictive setting capable of safely meeting the participant's needs. Potential options may include enhanced community-based services, assisted living, skilled nursing, medical respite, residential treatment, crisis stabilization, inpatient treatment, or another appropriate setting. Assessment may occur during screening or admission, following hospitalization or crisis intervention, after a significant change in condition or functioning, during ongoing services when clinically indicated, at discharge, or whenever a participant or staff member raises a concern. Indicators include psychiatric or medical crises, significant safety concerns, worsening behavioral health or substance use symptoms, cognitive decline, medication-management concerns, mobility limitations, inability to perform activities of daily living, frequent emergency department use or hospitalization, or a need for supervision, nursing, treatment, or personal care beyond what the PSH program can provide.

For non-emergent concerns, the Program Manager and licensed clinical staff coordinate a person-centered assessment of the participant's clinical and functional needs, risks, existing supports, environmental factors, and preferences. Standardized screening tools may also be used to support clinical decision-making. When appropriate, the participant may remain in PSH with an updated Care Plan, increased monitoring, enhanced community-based services, or additional supports.

When a higher level of care is clinically recommended, VOAF provides a warm referral and assists with applications, records, benefits, transportation, coordination with the receiving provider, and development of a safe transition plan. Urgent or emergent conditions receive immediate crisis or emergency intervention. All assessments, recommendations, referrals, participant preferences, transition or risk-reduction plans, and follow-up activities are documented in the clinical record and reviewed through clinical supervision and quality-improvement activities.

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)

Volunteers of America of Florida (VOAF) uses its Stages of Change Assessment policy to evaluate each Permanent Supportive Housing participant's readiness to address housing, health, recovery, behavioral health, and independent-living goals, including readiness to transition to unsubsidized or other permanent housing when appropriate. Readiness is assessed individually by goal and may change over time based on the participant's circumstances, progress, preferences, functional abilities, and available supports.

Staff assess each participant's stage of change during the initial assessment and Care Plan process and reassess readiness during scheduled Care Plan reviews, following significant changes in condition or circumstances, when progress has stalled, when the participant identifies a new goal, and prior to discharge or transition. Assessment considers the participant's expressed priorities, recent behavior, previous efforts toward identified goals, barriers, strengths, and available supports.

For participants considering a move from Permanent Supportive Housing, this process allows staff to evaluate readiness for increased housing independence and work collaboratively with the participant to establish measurable, person-centered goals and appropriate interventions. When a participant demonstrates readiness and expresses a desire to move on, staff can incorporate transition-related goals into the Care Plan and support planning for other permanent housing options consistent with the participant's needs and preferences.

Readiness determinations, the participant's perspective, supporting information, and corresponding interventions are documented in the clinical record, Care Plan, and progress notes. Readiness is reassessed throughout participation and prior to transition. A participant's lack of readiness to move on does not constitute noncompliance and does not result in discharge from Permanent Supportive Housing. VOAF respects participant choice and self-determination while supporting participants who are ready and able to pursue 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?	No
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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.	08/04/2026
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1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
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	Describe:
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

1. The CoC refers to the HUD Notice of Funding Availability (NOFO) to establish the funding criteria for the FY 2026 Continuum of Care (CoC) Program. Project applications submitted to the CoC for inclusion on the FY 2026 Priority Listings must be reviewed & either accepted or rejected by the CoC. Consideration will also be given to the reallocation of funding between projects to either generate a new project application under the bonus & reallocation process or to shift funds in whole or part from an existing eligible renewal project that is under performing to create one or more new projects that meet our CoC priorities w/out decreasing the CoC's ARD. All applicants received a copy of the reallocation process. The Review Panel reviewed & scored all eligible projects for inclusion in the 2026 HUD CoC application by reviewing SAGE, SPM, eLOCCS & APRs to assess project performance. 2. Reallocation for a PSH Renewal, VOA, was presented by the PSH agency VOA based on the priorities and goals of the 2026 HUD CoC NOFO related to PSH and the stated investment of TH projects. The agency receiving PSH funds voluntarily chose to reallocate the funded renewal PSH project to TH project reallocation from PSH to TH. The CoC determined whether the remaining renewal projects were low performing or less needed criteria for our CoC & therefore, would be eligible for reallocation, based on the review panel scoring forms for each application. It was determined the projects seeking renewals are all eligible for renewal &, therefore, included in the 2026 HUD CoC application. It was determined that no remaining renewal projects were low performing or less need & no reallocation was needed. 3.No projects were determined to be low performing or less needed during the local competition this year & therefore, no reallocation was needed other than the agency that volunteered to reallocate funds from PSH to PSH to TH. 4. There were no low performing or less needed programs in our CoC, therefore, the reallocation process was not needed.

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

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

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

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

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

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

(limit 2,500 characters)

1. Not applicable. 2. Not applicable.

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

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

(limit 2,500 characters)

UWSV, rural CoC, implemented a street outreach effort (.5 FTE staff) closing the gap of a loss of two street outreach programs within the CoC during the 01/01/2025-12/31/2025 period. Coordinating with local law enforcement agencies, there are various homeless encampments scattered throughout the City of Lake Cities boundaries. Many move between private properties inside the jurisdiction. The encampments are disbanded when a property owner requests that they be removed. Occasionally a tent will be present on the property of a business and will be removed at the request of owner or management. These encampments are usually situated deep inside wooded areas that are not immediately visible to patrolling officers unless they are made aware of their presence through street outreach efforts. Tracking these encampments prove difficult with the shortage of street outreach in our rural CoC and our region has been deemed fiscally constrained and are not included in the Florida Statute for encampment action.

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.	6
2. Enter the reduction in the number of encampments during your evaluation period.	2

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.	10
2. Enter the reduction in the number of people in encampments during your evaluation period.	8

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)

Street outreach efforts have been successful in reducing the number of encampments in a specific area by connecting the encampment residents to CE and completing a screening for housing assistance. The street outreach worker has successfully placed 8 in housing during this time period, ensuring linkages for mainstream benefits, including SNAP, Medicaid and assisting with employment, education and counseling if needed to remain self sufficient after services have ended.

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)

There was a slight decrease in first time homelessness in our rural CoC. The rural CoC utilizes CE and an assessment question that inquires about an individual's/families' history of homelessness. This question, along with history data recorded in HMIS, can be used to determine if the individual/family has experienced homelessness in the past. Best evidence based strategies seem to be providing supportive services and participation agreements to address the root causes of homelessness. Economic challenges, housing inventory, available behavioral health services and lack of early interventions can be barriers to self sufficiency. The CoC is applying for more supportive services and increasing bed counts to expand access to street outreach, treatment for substance use, job training, and child care, healthcare, counseling and case management to remove the barriers and build better environments the help build self sufficiency to end the learned helplessness and end the cycle of indefinite housing insecurity. The network of supportive services through non-profit agencies and faith based organizations will help reduce the number of first time homeless families and individuals by enhancing a diverse inventory of options for assistance for those at risk of homelessness in hopes of remaining housed with the supports of the community resources. Continuing the CoC's plan for intensive case management weekly meetings with all clients seeking housing assistance and continued case management after assistance has ended for those engaged will help the efforts of the CoC to continue to decrease the first time homeless in our area.

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)

Our rural CoC is seeing an increase of homelessness in our entire geographical region, which relationally causes an increase in the time someone remains homeless. According to discussion with stakeholders and data from system performance, severs shortage of affordable housing, rising rent and evictions and lack of housing vouchers are environmental housing market barriers, along with gaps in funding or underfunding for specific subpopulations, and lack of shelter beds in our rural communities contribute to the increase of LOT homeless for families and individuals in our CoC. Strategies for improving the increase would include the following techniques: improve housing placement by improving landlord engagement, optimize voucher utilization in our CoC, seek revitalization funds for areas of housing insufficiencies, streamline CE to identify housing matches quickly, increase TH and supportive services to help remove barriers that keep families and individuals homeless (legal, behavioral and substance use issues). These strategies will be used to decrease the LOT homeless by 20% over the next 12 months.

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?

75.00%

Describe how you calculated the data for this response.

(limit 2,500 characters)

The HMIS System Admin and Lead HMIS for our CoC ran a CAPER with a reporting group created including all TH/RRH/PSH programs and took the total numbers of exits to PH without subsidies and divided it by the total number of exits to get a percentage for 2A-7.

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

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	28	72	84	84.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	27	0	27	100.00%
4. Rapid Re-Housing (RRH) beds	170	23	193	100.00%
5. Permanent Supportive Housing (PSH) beds	24	0	11	46.00%
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)

PSH - 1. The bed coverage rate for PSH beds is less than 84.99% as a result of a single factor, absence of HMIS entry of HUD VASH beds managed by a PHA outside the CoC area. Total beds in HMIS reported in HDX is 11 & includes 100% of beds in a HUD CoC PSH project. All other PSH beds counted included in the 2026 HIC are HUD VASH beds managed by the NW FL Housing Authority, outside of the CoC jurisdiction almost 200 miles away. Steps the CoC will take over the next 12 months to increase the bed coverage rate to at least 85% for PSH will be a letter to the NW FL Housing Authority requesting consideration to add the HUD VASH beds to the CoC's HMIS bed coverage. This will be followed up w/ a phone call by the homeless coalition lead agency executive director. Should such written & verbal appeal result in agreement by the NW FL Housing Authority to include HUD VASH beds in the CoC HMIS, add'l steps necessitated include adding the agency as an HMIS provider, including entering into an HMIS MOA; adding HMIS entry staff as system user(s); providing the necessary data entry paperwork; & providing training to data entry staff member(s) remotely due to the distance. In the absence of an affirmative response, consultation will be made w/ other local CoCs w/ HUD VASH units ported to the NW FL Housing Authority in an effort to (1) determine any workarounds identified or (2) conduct a collective appeal to the PHA. 2. The CoC will implement the steps above by generating a letter to the PHA administration. Remaining steps will be taken based on whether the response is affirmative, in which case the CoC will proceed w/ the steps identified above to include the PHA's HUD VASH units in the CoC HMIS bed coverage, or whether the response is negative, in which case the CoC will consult w/ fellow local CoCs whose HUD VASH units are ported to the NW FL Housing Authority to identify opportunities to secure data elements necessary to include the beds in HMIS bed coverage.

Emergency Shelter- 1. The rural CoC has a church supported men's shelter of 16 beds that have been invited to join HMIS free of charge just to get the information for the HIC and for data through the CoC. This has not been successful. Over the next 12 months, the HMIS lead will continue to work toward viable solution for all involved. 2. HMIS lead and CoC Staff will brainstorm ways to ease the burden of data entry for the church led shelter to include the utilization and bed coverage of the 16 beds.

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?	Yes

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	01. 1C-1. List of...	09/27/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	02. 1C-1f. List o...	09/27/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	03. 1C-3. Languag...	09/28/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	04. 1C-10. Eviden...	09/28/2026
05. 1D-1. Local Competition Scoring Tool	Yes	05. 1D-1. Local C...	09/27/2026

06. 1D-2c. Local Competition Selection Results	Yes	06. 1D-2c. Local ...	09/28/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	07. 2A-8b. FY 202...	09/28/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No	08. 3A-1. HUD-29...	09/28/2026
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: 01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment

Attachment Details

Document Description: 02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment

Attachment Details

Document Description: 03. 1C-3. Language from Project Supportive Service Agreements

Attachment Details

Document Description: 04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety

Attachment Details

Document Description: 05. 1D-1. Local Competition Scoring Tool

Attachment Details

Document Description: 06. 1D-2c. Local Competition Selection Results

Attachment Details

Document Description: 07. 2A-8b. FY 2026 HDX Competition Report

Attachment Details

Document Description: 08. 3A-1. HUD-2996 Certification for Opportunity
Zone Preference Points

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	09/28/2026
1C. Coordination and Engagement	09/28/2026
1D. Project Review/Ranking	09/28/2026
2A. HMIS Implementation	09/28/2026
3A. Policy Initiatives	09/28/2026
4A. Attachments Screen	09/28/2026
Submission Summary	No Input Required

01. 1C-1 List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment

FL-518 is a HUD Rural community. No On-site substance use treatments but all programs provide on-site case management.

Project Name	Project Type (TH/RRH/PSH)	Integrated Treatment Provider	Type of On-Site Substance Use Services Provided
CC RR	RR	Catholic Charities	
VOAF PSH-TH_UWSV	PSH-TH	Volunteers of America of Florida, Inc.	No on-site treatment only on-site Case Management
UWSV HUD RR Renewal	RR	United Way of Suwannee Valley	No on-site treatment only on-site Case Management
VOAF Launch Point Transitional Housing Program_UWSV	TH	Volunteers of America of Florida, Inc.	No on-site treatment only on-site Case Management

01. 1C-1 List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment

Project Name	Project Type (TH/RRH/PSH)	Integrated Treatment Provider	Type of On-Site Substance Use Services Provided
VOAF PSH-TH_UWSV	PSH-TH	Volunteers of America of Florida, Inc.	Behavioral Health, Treatment, Recovery, Case Management
VOA Lake City PSH 2026	PSH	Volunteers of America of Florida, Inc.	Behavioral Health, Treatment, Recovery, Case Management
VOAF Launch Point Transitional Housing Program_UWSV	TH	Volunteers of America of Florida, Inc.	Behavioral Health, Treatment, Recovery, Case Management



United Way of Suwannee Valley

Supportive Service Agreement

HMIS# _____

NAME: _____ DATE: _____

PHONE #s: _____ EMAIL: _____

The United Way of Suwannee Valley has referred your information to a case manager on staff. Per written grant rules, there is a minimum contract of weekly contact. The client _____, agrees to abide by this contractual agreement and keep in contact with their assigned case worker via phone or in-person visits.

BY SIGNING THIS FORM, I, _____, UNDERSTAND THAT:

- I agree to contact my case manager with ANY changes or updates to my living situation including where I am sleeping at night (if homeless); if I have found a place to rent; if someone no longer lives in my household; or if I am no longer interested in receiving housing assistance from UWSV.
- I agree to contact my case manager at least once a week with updates regarding my situation including: any changes to the established case plan; any housing changes; updates to my job(s); updates with landlord; etc.
- I agree to send my case manager my monthly bills if they are to pay including: electric (lights); water; and rent.
- It is my responsibility to contact my case manager and to keep them updated on any changes to my case.

I understand to receive services in this program, I will abide by 24 CFR 578.75 stating participation is required for supportive services. Examples of supportive services are, but not limited to, case management requirement, substance use treatments, employment training, counseling, volunteering, or other approved activities, to further my housing stability plan goals for self-sufficiency.

I understand after 28 days of no contact from me with my case manager I am subject to be exited from the program and will not receive further financial assistance.

Printed name of Head of Household

Signature of Head of Household

Date

Printed Name of Case Manager

Signature of Case Manager

Date

I UNDERSTAND IF I DO NOT CONTACT MY CASE MANAGER IN MORE THAN 28 DAYS I AM SUBJECT TO REMOVAL FROM THE HOUSING ASSISTANCE PROGRAM AND WILL NO LONGER RECEIVE FINANCIAL ASSISTANCE.

Volunteers of America of Florida, Inc.
Launch Point Transitional Housing Program
Supportive Services Agreement

Participant Name: _____

Unit #: _____ Date of Admission: _____

I, _____, do hereby understand and acknowledge the following:

1. The goal of this VOAF Launch Point Transitional Housing Program is to help me improve my health and wellness, housing stability, and increased employment income leading to financial stability and self-sufficiency. On call staff are available after hours as needed.
2. In order to qualify for this program, as a participant I agree that I must engage in at least **20 hours every week** of individualized **services, activities or employment**. Examples of services or activities include case management, counseling, treatment, volunteering, work therapy, education, job training, community building activities. Participants who are employed may count verified work hours toward meeting this requirement on an hour-for-hour basis. Only program participants **over age 62** or who is an individual with **handicaps** as defined in 24 CFR 8.3 or a with a developmental disability as defined under 24 CFR 578.3 may be exempt from the 20 hour per week requirement.
3. In order to identify and achieve pertinent goals, I will work with staff to create a **Housing Stability Plan** that will include the services to be provided, when and how often services will be provided, by whom all services will be provided; program participant goals, strategies for achieving those goals, and target dates for achievement to focus on improved health and wellness, housing stability, and increased employment income leading to financial stability and self-sufficiency.
4. I understand that during my stay in the program, I must comply with the Housing Stability Plan process and follow its directives in order to move from dependence to self-sufficiency.
5. **Service participation** requirements for VOAF Launch Point Transitional Housing Program must include the following components:

Case Management

- Participants are required to engage in ongoing case management services.
- A meeting between the participant and the assigned case manager must occur at least once per month.

Housing Stability Plan

- Participants must complete a Housing Stability Plan at program intake.

Volunteers of America of Florida, Inc.
Launch Point Transitional Housing Program
Supportive Services Agreement

- The HSP must be reviewed and updated according to the schedule established in the plan and, at a minimum:
- Quarterly for TH participants

Financial Assessment

- Participants must complete a Financial Assessment at intake.
- The assessment must be updated at least **annually**, including in preparation for lease renewal when applicable.

Life Skills Participation

- Participants must engage in life skills activities that support the goals identified in their Housing Stability Plan.
- Additional life skills activities may be required when participant needs or challenges are identified during program participation.
- Examples include, but are not limited to:
- Budgeting and financial management classes for participants experiencing late rent or utility payments, as applicable
- Time management training for participants who frequently miss appointments;
- Household management education following failed unit inspections; and
- Other skill-building activities designed to support long-term housing stability and self-sufficiency.

6. Upon achieving my goals towards attaining self sufficiency, I along with staff, will implement a Discharge Plan from the program.
7. I must comply with the **House Rules** and **Occupancy/Lease Agreement**.
8. If it is determined that I am not in compliance with my Housing Stability Plan, House Rules or Occupancy/Lease Agreement then I will be subject to termination from the program.

I along with staff shall sign a copy of this agreement at the beginning of the Occupancy/Lease Agreement upon admission to the VOF Launch Point Transitional Housing Program. I will receive a copy along with my Occupancy/Lease Agreement and one will be kept in my VOF Participant File.

I acknowledge that I have read the above mentioned provisions and agree to abide by them. I understand that failure to do so may result in termination.

Participant Date

Staff Date

CATHOLIC CHARITIES SUPPORTIVE SERVICES AGREEMENT

Catholic Charities wants to help you reach your goals and become more stable and independent. As part of this program, you may be asked to participate in services that can help you overcome barriers and reach your goals.

These services may include:

- Meeting regularly with your Case Manager;
- Creating and following a personal service plan;
- Job search, job readiness, or employment training;
- Education or vocational training;
- Budgeting and financial education;
- Life-skills training;
- Help finding or keeping a job;
- Substance use disorder treatment, when appropriate and allowed by the program; and
- Referrals to other community services that may help you.

Your Agreement

I understand that participation in some supportive services may be required for me to continue receiving assistance through this program.

I agree to work with my Case Manager to identify the services that will best help me reach my goals. I understand that I am expected to attend scheduled meetings, participate in required services, and make reasonable efforts to complete the goals in my service plan.

The services I am asked to participate in will be based on my individual needs and the requirements of the program.

Disability-Related Services

I understand that, under **24 CFR § 578.75(h)**, Catholic Charities will not require me to participate in disability-related services as a condition of continuing in the program. Disability-related services may include mental health services, health services, or medication provided to address a disability.

If the purpose of a project is to provide substance abuse treatment, participation in that treatment may be required as allowed by federal regulations and program requirements.

Participant Acknowledgment

By signing below, I confirm that:

- This agreement has been explained to me.
- I understand what is expected of me.
- I have had an opportunity to ask questions.
- I understand that participation in required supportive services may be a condition of continuing in the program.

Participant Printed Name: _____

Participant Signature: _____

Date: _____

Case Manager Printed Name: _____

Case Manager Signature: _____

Date: _____

Memorandum of Understanding

Between Columbia County Sheriff Office

And

**United Way of Suwannee Valley, Inc.
Lead Agency for the Columbia, Hamilton, Lafayette, Suwannee Counties CoC**

In the interest of maintaining effective collaborative efforts for the provision of services to individuals that are mutually served, the following Agreement is established:

A. Agreement

The parties will conduct a periodic review of this Agreement in order to ensure that the provisions are current. The parties may revise this Agreement at any time by mutual consent.

B. Target Population

Individuals or families which are homeless or at risk of homelessness.

C. Responsibilities

(Agency) Columbia County Sheriff Office agrees to:

- Maintain membership and ongoing participation in the CoC, including applicable committees
- Share information about resources or programs to assist persons who are homeless or at risk of homelessness
- Exchange client-related information with appropriate authorization in order to ensure client/client family services
- Refer clients to UWSV who are at risk of homelessness
- Refer clients who are literally homeless to the UWSV coordinate entry coordinator

United Way of Suwannee Valley Inc. agrees to:

- Provide information to (Agency) Columbia County Sheriff Office staff about available services through UWSV including eligibility guidelines
- Share information about resources that are available to assist our mutual clients
- Respond to referrals received from (Agency) Columbia County Sheriff Office by providing assistance, depending on program eligibility and to the extent provided for based upon funding sources available and their defined levels of assistance as well as United Way's written standards for such programs

Addendum

- Support the removal of tents and encampments and work alongside efforts to transition eligible individuals to transitional housing
- Offer support contacting the mobile crisis unit and local supportive services for persons in crisis of self-harm and harm to others
- Report illegal drug use and discourage the use of illegal substances and refer persons to local substance abuse programs
- Communicate and coordinate data in accordance with the Sex Offender Registry and Notification Act

- Direct referrals from(Agency) Columbia County Sheriff Office into United Way of Suwannee Valley's Coordinated Entry process
- Maintain and distribute to clients(Agency) Columbia County Sheriff Office informational brochure on United Way of Suwannee Valley Programs.

This agreement shall take effect on 11-01-2025.

Jennifer Anchores, LCSW

Signature of United Way Representative

Executive Director

Title

[Handwritten Signature]

Signature of Agency Representative

Sheriff

Title

Memorandum of Understanding

Between Community Paramedic

And

**United Way of Suwannee Valley, Inc.
Lead Agency for the Columbia, Hamilton, Lafayette and Suwannee Counties
Continuum of Care/Homeless Coalition**

In the interest of maintaining effective collaborative efforts for the provision of services to individuals that are mutually served, the following Agreement is established:

A. Agreement

The parties will conduct a periodic review of this Agreement in order to ensure that the provisions are current. The parties may revise this Agreement at any time by mutual consent.

B. Target Population

Individuals or families which are homeless or at risk of homelessness.

C. Responsibilities

(Agency) Community Paramedic agrees to:

- Maintain membership and ongoing participation in the Continuum of Care/ Homeless Coalition, including applicable committees.
- Share information about resources or programs to assist persons who are homeless or at risk of homelessness.
- Exchange client-related information with appropriate authorization in order to ensure client/client family services.
- Refer clients to UWSV who are at risk of homelessness
- Refer clients who are literally homeless to the UWSV coordinate entry coordinator
- Offer training to United Way of Suwannee Valley staff.

United Way of Suwannee Valley Inc. agrees to:

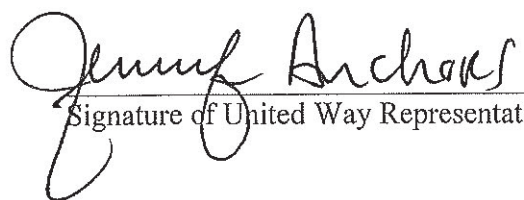
- Provide information to (Agency) Community Paramedic staff about available services through UWSV including eligibility guidelines.
- Share information about resources that are available to assist our mutual clients.
- Respond to referrals received from (Agency) Community Paramedic by providing assistance, depending on program eligibility and to the extent provided for based upon funding sources available and their defined levels of assistance as well as United Way's written standards for such programs.

Addendum

- Support the removal of tents and encampments and work alongside efforts to transition eligible individuals to transitional housing
- Offer support contacting the mobile crisis unit and local supportive services for persons in crisis of self-harm and harm to others
- Report illegal drug use and discourage the use of illegal substances and refer persons to local substance abuse programs
- Communicate and coordinate data in accordance with the Sex Offender Registry and Notification Act

- Direct referrals from (Agency) Community Paramedic into United Way of Suwannee Valley's Coordinated Entry process.
- Maintain and distribute to clients (Agency) Community Paramedic informational brochure on United Way of Suwannee Valley Programs.
- Refer appropriately assessed clients to (Agency) Community Paramedic for services.

This agreement shall take effect on 11-01-2025.


Signature of United Way Representative

Executive Director

Title


Signature of Agency Representative

Chief
Title

Memorandum of Understanding

Between Lafayette County Sheriff's Office

And

**United Way of Suwannee Valley, Inc.
Lead Agency for the Columbia, Hamilton, Lafayette and Suwannee Counties
Continuum of Care/Homeless Coalition**

In the interest of maintaining effective collaborative efforts for the provision of services to individuals that are mutually served, the following Agreement is established:

A. Agreement

The parties will conduct a periodic review of this Agreement in order to ensure that the provisions are current. The parties may revise this Agreement at any time by mutual consent.

B. Target Population

Individuals or families which are homeless or at risk of homelessness.

C. Responsibilities

(Agency) Lafayette County Sheriff's Office agrees to:

- Maintain membership and ongoing participation in the Continuum of Care/ Homeless Coalition, including applicable committees.
- Share information about resources or programs to assist persons who are homeless or at risk of homelessness.
- Exchange client-related information with appropriate authorization in order to ensure client/client family services.
- Refer clients to UWSV who are at risk of homelessness
- Refer clients who are literally homeless to the UWSV coordinate entry coordinator
- Offer training to United Way of Suwannee Valley staff.

United Way of Suwannee Valley Inc. agrees to:

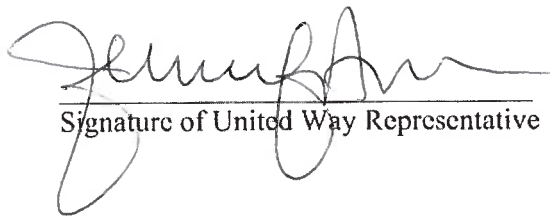
- Provide information to (Agency) Lafayette County Sheriff's Office staff about available services through UWSV including eligibility guidelines.
- Share information about resources that are available to assist our mutual clients.
- Respond to referrals received from (Agency) Lafayette County Sheriff's Office by providing assistance, depending on program eligibility and to the extent provided for based upon funding sources available and their defined levels of assistance as well as United Way's written standards for such programs.

Addendum

- Support the removal of tents and encampments and work alongside efforts to transition eligible individuals to transitional housing
- Offer support contacting the mobile crisis unit and local supportive services for persons in crisis of self-harm and harm to others
- Report illegal drug use and discourage the use of illegal substances and refer persons to local substance abuse programs
- Communicate and coordinate data in accordance with the Sex Offender Registry and Notification Act

- Direct referrals from(Agency) Lafayette County Sheriff's Office into United Way of Suwannee Valley's Coordinated Entry process.
- Maintain and distribute to clients(Agency) Lafayette County Sheriff's Office informational brochure on United Way of Suwannee Valley Programs.
- Refer appropriately assessed clients to(Agency) Lafayette County Sheriff's Office for services.

This agreement shall take effect on 11-01-2025.



Signature of United Way Representative

Executive Director

Title



Signature of Agency Representative

SHERIFF

Title

Memorandum of Understanding

Between Lake City Police Department

And
United Way of Suwannee Valley, Inc.
Lead Agency for the Columbia, Hamilton, Lafayette & Suwannee Counties
Continuum of Care/Homeless Coalition

In the interest of maintaining effective collaborative efforts for the provision of services to individuals that are mutually served, the following Agreement is established:

A. Agreement

The parties will conduct a periodic review of this Agreement in order to ensure that the provisions are current. The parties may revise this Agreement at any time by mutual consent.

B. Target Population

Individuals or families which are homeless or at risk of homelessness.

C. Responsibilities

(Agency) Lake City Police Department agrees to:

- Maintain membership and ongoing participation in the Continuum of Care/ Homeless Coalition, including applicable committees
- Share information about resources or programs to assist persons who are homeless or at risk of homelessness
- Exchange client-related information with appropriate authorization in order to ensure client/client family services
- Refer clients to UWSV who are at risk of homelessness
- Refer clients who are literally homeless to the UWSV coordinate entry coordinator
- Offer training to United Way of Suwannee Valley staff.

United Way of Suwannee Valley Inc. agrees to:

- Provide information to (Agency) Lake City Police Department staff about available services through UWSV including eligibility guidelines
- Share information about resources that are available to assist our mutual clients
- Respond to referrals received from (Agency) Lake City Police Department by providing assistance, depending on program eligibility and to the extent provided for based upon funding sources available and their defined levels of assistance as well as United Way's written standards for such programs

Addendum

- Support the removal of tents and encampments and work alongside efforts to transition eligible individuals to transitional housing
- Offer support contacting the mobile crisis unit and local supportive services for persons in crisis of self-harm and harm to others
- Report illegal drug use and discourage the use of illegal substances and refer persons to local substance abuse programs
- Communicate and coordinate data in accordance with the Sex Offender Registry and Notification Act

- Direct referrals from(Agency) Lake City Police Department into United Way of Suwannee Valley's Coordinated Entry process
- Maintain and distribute to clients(Agency) Lake City Police Department informational brochure on United Way of Suwannee Valley Programs.
- Refer appropriately assessed clients to(Agency) Lake City Police Department for services.

This agreement shall take effect on 11-01-2025.

Jennifer Anchors

Signature of United Way Representative



Signature of Agency Representative

Executive Director

Title

Chief of Police

Title

Ranking and Scoring

Detailed Ranking and Scoring Criteria: The Review Panel will use a 200-point scoring framework to evaluate eligible applications. Projects must first pass threshold review, including applicant eligibility, timely submission, completeness, HUD-eligible activities and costs, required match documentation, HMIS or comparable database participation, Coordinated Entry participation, financial capacity, and absence of unresolved compliance concerns that would prevent award. Projects that do not pass threshold review may be rejected and not ranked.

The Review Panel may also consider HUD funding priorities, local competition requirements, project component type, renewal performance, reallocation opportunities, transition grant proposals, DV Bonus requirements, YHDP requirements, and whether a project strengthens the CoC's consolidated application. Final ranking recommendations will be based on score, threshold eligibility, HUD requirements, funding category, strategic value to the CoC, and the need to submit the strongest possible consolidated application.

Renewal projects may be reduced, reallocated, ranked lower, or not recommended if they demonstrate poor performance, low utilization, repeated underspending, unresolved monitoring findings, weak data quality, inability to document match, lack of participation in Coordinated Entry or HMIS, or failure to comply with HUD or HSNSV requirements. New projects will be evaluated on need, feasibility, applicant capacity, budget reasonableness, match, partnerships, service design, and alignment with HUD and CoC priorities.

Scoring Category	Points	Review Considerations
HUD NOFO Alignment and Eligible Project Design	30	Consistency with FY 2026 HUD CoC NOFO goals, eligible activities, eligible populations, project type requirements, CoC Action Plan priorities, and local system needs.
Performance and Outcomes	20	For renewals, prior performance on housing stability, exits to permanent housing, income and benefits, utilization, timeliness, spending, drawdowns, and grant compliance – APR. For new projects, reasonableness of projected outcomes and evidence supporting the proposed approach.
System Performance and Community Impact	25	Contribution to reducing homelessness, improving flow through the homeless response system, serving high-need populations, supporting Coordinated Entry, addressing documented gaps, and improving overall CoC performance.
Financial Capacity, Budget Reasonableness, and Match	30	Budget accuracy, eligible costs, cost effectiveness, match documentation, leveraged resources, financial controls, audit results, grant management capacity, and ability to administer federal funds.
Data Quality, HMIS, and Reporting Capacity	30	HMIS or comparable database participation, data completeness, timeliness, accuracy, reporting capacity, PIT participation, and compliance with HUD data standards and HSNSV HMIS policies.
Coordinated Entry and Local Participation	10	Participation in Coordinated Entry, access point responsibilities, coalition meeting participation, committee participation, collaboration with partners, and compliance with HSNSV policies and procedures.
Supportive Services, Self-Sufficiency, Recovery, Employment, and Mainstream Benefits	25	Strength of services that support housing stability, treatment or recovery access where appropriate, employment, education, childcare, transportation, mainstream benefits, public safety, and long-term self-sufficiency.
Organizational Experience, Compliance, and Risk	30	Experience serving people experiencing homelessness, monitoring history, unresolved findings, corrective actions, staff capacity, board oversight, and overall risk to successful project implementation.

Summary of the 200-Point Ranking Framework: The scoring framework totals 200 points and is used to compare eligible project applications in a consistent and documented manner. Before scoring, each application must pass threshold review. Threshold review confirms that the application was submitted on time, is complete, proposes eligible activities and costs, identifies required match, demonstrates applicant eligibility and capacity, and meets HMIS, Coordinated Entry, and compliance expectations. Applications that pass threshold review are scored across eight categories: HUD NOFO alignment and project design; performance and outcomes; system performance and community impact; financial capacity, budget reasonableness, and match; data

quality and HMIS reporting; Coordinated Entry and local participation; supportive services and self-sufficiency; and organizational experience, compliance, and risk. Scores should reflect the strength of the evidence provided in the application, not reviewer assumptions or information outside the submitted materials.

How Scores Should Be Used: The numerical score helps establish a preliminary rank order; however, the final ranking recommendation may also consider HUD funding rules, project component type, renewal obligations, reallocation decisions, bonus funding requirements, YHDP requirements, project feasibility, and the overall competitiveness of the CoC consolidated application. Reviewers should document any reason a project is recommended for reduced funding, lower ranking, reallocation, conditional approval, or rejection.

Attachment A: Rank and Review Scoring Form

Applicant Name	
Project Name	
Project Type/Funding Category	
Renewal, New, Expansion, Reallocation, Transition, Bonus, DV Bonus, YHDP, HMIS, Planning, or Other	
Reviewer Name	
Date Reviewed	

Reviewer Instructions: Reviewers must complete the threshold checklist before assigning points. If a project does not pass threshold review, the reviewer should mark the application as not eligible for scoring unless the Review Panel determines that a curable deficiency may be corrected within the local competition timeline. Reviewers must score only the information submitted with the application and required attachments. Reviewers should not rely on personal knowledge, assumptions, undocumented past experience, or verbal statements that are not included in the application record. Each score should be supported by brief comments explaining the evidence reviewed, strengths, concerns, missing documentation, risk factors, and the reason for any point deductions. Reviewers with an actual or perceived conflict of interest must disclose the conflict and recuse themselves from scoring, discussion, ranking, and voting for the affected application.

Threshold Review Checklist:

Threshold Requirement	Yes	No	Comments
Application submitted by the local deadline.			
Applicant is an eligible entity under HUD and local competition requirements.			
Application is complete and includes required local and HUD materials.			
Project activities and costs appear eligible for the proposed funding category.			
Required match is identified and documented.			

Applicant demonstrates financial and administrative capacity to manage federal funds.			
Applicant participates in HMIS or uses a comparable database if applicable.			
Applicant participates in Coordinated Entry and local CoC requirements.			
No unresolved compliance, monitoring, audit, or risk concerns prevent award.			
Threshold Determination: Pass or Fail			

200-Point Score Sheet:

Scoring Category	Maximum Points	Reviewer Score	Reviewer Comments
HUD NOFO Alignment and Eligible Project Design	30		
Performance and Outcomes	20		
System Performance and Community Impact	25		
Financial Capacity, Budget Reasonableness, and Match	30		
Data Quality, HMIS, and Reporting Capacity	30		
Coordinated Entry and Local Participation	10		
Supportive Services, Self-Sufficiency, Recovery, Employment, and Mainstream Benefits	25		
Organizational Experience, Compliance, and Risk	30		
Total Score	200		

Examples for Applying Scoring Criteria:

Scoring Category	Strong Score Example	Partial Score Example	Low or No Score Example
HUD NOFO Alignment and Eligible Project Design	The project clearly identifies the eligible project type, eligible population, eligible costs, HUD funding category, local need, and how the design aligns with the FY 2026 HUD CoC NOFO and CoC Action Plan.	The project is generally eligible but does not fully explain the funding category, target population, local need, or connection to HUD and CoC priorities.	The project design is unclear, appears inconsistent with HUD requirements, lacks a defined eligible population, or includes activities or costs that may be ineligible.
Performance and Outcomes	A renewal project demonstrates strong housing stability, spending, utilization, data quality, and outcome performance; or	The project shows mixed performance, limited outcome detail, moderate underspending, or projected outcomes	The project has poor performance, low utilization, repeated underspending, weak outcomes, missing performance data, or

	a new project provides realistic projected outcomes supported by evidence and experience.	that are reasonable but not well supported.	unsupported projected outcomes.
System Performance and Community Impact	The project addresses a documented local gap, serves high-need households, improves system flow, reduces homelessness, and strengthens the CoC consolidated application.	The project addresses a need but provides limited evidence of system impact or does not clearly explain how it will improve CoC performance.	The project does not address a documented need, duplicates existing resources without justification, or has little demonstrated impact on the homeless response system.
Financial Capacity, Budget Reasonableness, and Match	The budget is complete, eligible, reasonable, cost-effective, supported by documentation, and includes clear, verifiable match commitments.	The budget is mostly complete but has minor unclear costs, limited budget narrative, incomplete leverage detail, or match documentation that needs clarification.	The budget is incomplete, includes questionable or ineligible costs, lacks cost justification, or does not document required match.
Data Quality, HMIS, and Reporting Capacity	The applicant demonstrates timely, accurate, and complete HMIS or comparable database participation, strong reporting capacity, and compliance with HUD data standards and local HMIS policies.	The applicant participates in HMIS or a comparable database but has minor data quality issues, limited reporting detail, or inconsistent timeliness.	The applicant does not participate as required, has significant unresolved data quality problems, or lacks capacity to meet reporting requirements.
Coordinated Entry and Local Participation	The applicant actively participates in Coordinated Entry, accepts referrals, attends required meetings, participates in committees, and complies with HSNSV policies and procedures.	The applicant participates in some local processes but has inconsistent meeting attendance, limited committee involvement, or unclear Coordinated Entry procedures.	The applicant does not participate in Coordinated Entry, does not meet local participation expectations, or does not demonstrate collaboration with the CoC.
Supportive Services, Self-Sufficiency, Recovery, Employment, and Mainstream	The project provides or connects participants to appropriate services that support housing stability, income, benefits, employment, education,	The project includes supportive services but lacks detail about service intensity, referral pathways, follow-up, or how	The project provides little or no service strategy, does not connect participants to mainstream benefits or employment

Benefits	treatment or recovery access where appropriate, and long-term self-sufficiency.	services will improve housing stability and income outcomes.	resources, or lacks meaningful housing stability supports.
Organizational Experience, Compliance, and Risk	The applicant has relevant experience, adequate staffing, strong governance, clean or resolved monitoring/audit history, and low implementation risk.	The applicant has relevant experience but some staffing, monitoring, audit, governance, or implementation concerns that appear manageable.	The applicant has limited experience, unresolved findings, weak controls, inadequate staffing, audit concerns, or significant risk to successful implementation.

Suggested Point Ranges: As a general guide, reviewers may award 90-100 percent of the available category points for a strong response with complete documentation and low risk; 50-89 percent for a response that is generally adequate but has gaps, limited documentation, mixed performance, or moderate risk; and 0-49 percent for a weak, incomplete, unsupported, ineligible, or high-risk response. Reviewers should use professional judgment and document the reason for each score.

Scoring Guidance: Reviewers should award full points when the application fully addresses the category, provides complete supporting documentation, demonstrates strong HUD and CoC alignment, and presents minimal implementation risk. Reviewers should award partial points when the application addresses the category but has gaps, limited documentation, weaker outcomes, unclear budget detail, or moderate risk. Reviewers should award few or no points when the application does not address the category, lacks required documentation, proposes ineligible or unclear activities, or presents significant performance, compliance, financial, or implementation concerns.

Final Review Panel Recommendation:

Recommendation	Mark One	Comments
Recommend for inclusion in HUD CoC application.		
Recommend with conditions or required corrections.		
Do not recommend for inclusion.		
Recommend reduced funding, reallocation, or lower ranking.		
Recommended Rank		
Recommended Funding Amount		
Reviewer Signature		

2026 Local Competition Selection Results for all Projects

Project Name	Score	Status	Rank	Requested Funding / Reallocated Funds	Component
1 HMIS Renewal	*	Ranked	1	36255	0 HMIS
2 CE Renewal	*	Ranked	2	22973	0 SSO CE
3 HUD RR Renewal	400	Ranked	3	136040	0 PH - RR
4 SSO CE Bonus	400	Ranked	4	75000	0 CoC Bonus
5 VOAF Launch	250	Ranked	6	540886	247422 CoC Bonus + Reallocation
Lake City renewal		Reallocated	0	0	-247422 Reallocated
6 Another Way Home	295	Ranked	5	114917	DV Bonus
7 CC RR Bonus	215	Ranked	7	50000	CoC Bonus
8 SSO SO Bonus	230	Ranked	8	75000	CoC Bonus
					75000
					300000
					98741
					50000
					75000

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

FL-518 - Columbia, Hamilton, Lafayette, Suwannee 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

FL-518 - Columbia, Hamilton, Lafayette, Suwannee 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

FL-518 - Columbia, Hamilton, Lafayette, Suwannee 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	89	25.4	24.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	140	95.0	34.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

b. This measure is based on data element 3.917

This measure includes data from each client’s Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client’s entry date, effectively extending the client’s entry date backward in time. This “adjusted entry date” is then used in the calculations just as if it were the client’s actual entry date.

Metric	Universe (Persons)	Average		Median	
		Homeless (bed nights)	LOT	Homeless (bed nights)	LOT
1.1 Persons in ES-EE, ES-NbN, SH, and PH (prior to “housing move in”)	284	289.9		166.0	
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	334	284.7		171.0	

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

Measure 2: Returns to Homelessness for Persons who Exit to Permanent Housing (PH) Destinations

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range. Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

Metric	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	
	Count	Count	% of Returns	Count	% of Returns	Count	% of Returns	Count	% of Returns
Exit was from SO	7	0	0.0%	2	28.6%	0	0.0%	2	28.6%
Exit was from ES	80	18	22.5%	4	5.0%	2	2.5%	24	30.0%
Exit was from TH	23	1	4.4%	0	0.0%	1	4.4%	2	8.7%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	263	9	3.4%	11	4.2%	15	5.7%	35	13.3%
TOTAL Returns to Homelessness	373	28	7.5%	17	4.6%	18	4.8%	63	16.9%

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC
FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

Please refer to PIT section for relevant data.

Metric 3.2 – Change in Annual Counts

This measures the change in annual counts of sheltered homeless persons in HMIS.

Metric	Value
Universe: Unduplicated Total sheltered homeless persons	143
Emergency Shelter Total	90
Safe Haven Total	0
Transitional Housing Total	53

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

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

This measure is divided into six tables capturing employment and non-employment income changes for system leavers and stayers. The project types reported in these metrics are the same for each metric, but the type of income and universe of clients differs. In addition, the projects reported within these tables are limited to CoC-funded projects.

Metric 4.1 – Change in earned income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	7
Number of adults with increased earned income	2
Percentage of adults who increased earned income	28.6%

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	7
Number of adults with increased non-employment cash income	1
Percentage of adults who increased non-employment cash income	14.3%

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

Metric	Value
Universe: Number of adults (system stayers)	7
Number of adults with increased total income	3
Percentage of adults who increased total income	42.9%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	34
Number of adults who exited with increased earned income	0
Percentage of adults who increased earned income	0.0%

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC
FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

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

Metric	Value
Universe: Number of adults who exited (system leavers)	34
Number of adults who exited with increased non-employment cash income	0
Percentage of adults who increased non-employment cash income	0.0%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	34
Number of adults who exited with increased total income	0
Percentage of adults who increased total income	0.0%

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

Measure 5: Number of Persons who Become Homeless for the First Time

This measures the number of people entering the homeless system through ES, SH, or TH (Metric 5.1) or ES, SH, TH, or PH (Metric 5.2) and determines whether they have any prior enrollments in the HMIS over the past two years. Those with no prior enrollments are considered to be experiencing homelessness for the first time.

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

Metric	Value
Universe: Person with entries into ES-EE, ES-NbN, SH or TH during the reporting period.	121
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.	18
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)	103

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

Metric	Value
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	572
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.	74
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.)	498

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD’s Homeless Definition in CoC Program-funded Projects

Measure 6 is not applicable to CoCs in this reporting period.

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

This measures positive movement out of the homeless system and is divided into three tables: movement off the streets from Street Outreach (Metric 7a.1); movement into permanent housing situations from ES, SH, TH, and RRH (Metric 7b.1); and retention or exits to permanent housing situations from PH (other than PH-RRH).

Metric 7a.1 – Change in SO exits to temp. destinations, some institutional destinations, and permanent housing destinations

Metric	Value
Universe: Persons who exit Street Outreach	14
Of persons above, those who exited to temporary & some institutional destinations	0
Of the persons above, those who exited to permanent housing destinations	2
% Successful exits	14.3%

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

Metric 7b.1 – Change in ES, SH, TH, and PH-RRH exits to permanent housing destinations

Metric	Value
Universe: Persons in ES-EE, ES-NbN, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	622
Of the persons above, those who exited to permanent housing destinations	514
% Successful exits	82.6%

Metric 7b.2 – Change in PH exits to permanent housing destinations or retention of permanent housing

Metric	Value
Universe: Persons in all PH projects except PH-RRH who exited after moving into housing, or who moved into housing and remained in the PH project	7
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	7
% Successful exits/retention	100.0%

2025 HDX Competition Report

2026 Competition Report - SPM Data

FL-518 - Columbia, Hamilton, Lafayette, Suwannee Counties CoC

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

System Performance Measures Data Quality

Data coverage and quality will allow HUD to better interpret your SPM submissions.

Metric	ALLES, SH	ALL TH	ALL PSH, OPH	ALL RRH	All Street Outreach
Unduplicated Persons Served (HMIS)	90	53	8	662	5
Total Leavers (HMIS)	83	33	1	532	5
Destination of Don't Know, Refused, or Missing (HMIS)	0	0	0	30	2
Destination Error Rate (Calculated)	0.0%	0.0%	0.0%	5.6%	40.0%

2025 HDX Competition Report

2026 Competition Report - SPM Notes

FL-518 - Columbia, Hamilton, Lafayette, Suwannee 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.	

2025 HDX Competition Report

2026 Competition Report - HIC Summary

FL-518 - Columbia, Hamilton, Lafayette, Suwannee 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 [†] Beds or Beds Affected by Natural Disaster*	Adjusted*** Total Year- Round, Current, Non- VSP Beds	Adjusted*** HMIS Bed Coverage Rate for Year-Round, Current Beds
ES	100	12	28	0	28	42.9%
SH	0	0	0	0	0	NA
TH	27	27	27	0	27	100.0%
RRH	193	170	170	0	170	100.0%
PSH	24	11	24	0	24	45.8%
OPH	0	0	0	0	0	NA
Total	344	220	249	0	249	88.4%

2025 HDX Competition Report

2026 Competition Report
FL-518 - Columbia, Hamilton,
For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year- Round, Current Beds	Total Year- Round, VSP Beds in an HMIS- Comparable Database	Total Year- Round, Current, VSP Beds	Removed From Denominator: OPH EHV† Beds or Beds Affected by Natural Disaster**	Adjusted*** Total Year- Round Current, VSP Beds	HMIS Comparable Bed Coverage Rate for VSP Beds
ES	100	72	72	0	72	100.00%
SH	0	0	0	0	0	NA
TH	27	0	0	0	0	NA
RRH	193	23	23	0	23	100.00%
PSH	24	0	0	0	0	NA
OPH	0	0	0	0	0	NA
Total	344	95	95	0	95	100.00%

2025 HDX Competition Report

2026 Competition Report
FL-518 - Columbia, Hamilton,
For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS-Comparable Database	Adjusted*** Total Year-Round, Current, Non-VSP and VSP Beds	HMIS and Comparable Database Coverage Rate
ES	100	84	100	84.00%
SH	0	0	0	NA
TH	27	27	27	100.00%
RRH	193	193	193	100.00%
PSH	24	11	24	45.83%
OPH	0	0	0	NA
Total	344	315	344	91.57%

2025 HDX Competition Report

2026 Competition Report - HIC Summary

FL-518 - Columbia, Hamilton, Lafayette, Suwannee 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

FL-518 - Columbia, Hamilton, Lafayette, Suwannee 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	59	92	112
Safe Haven Total	0	0	0
Transitional Housing Total	13	25	11
Total Sheltered Count	72	117	123
Total Unsheltered Count	455	382	313
Total Sheltered and Unsheltered Count*	527	499	436

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	0	15	8
Total Unsheltered Count	21	9	24
Total	21	24	32

Public Reporting Burden Statement: This collection of information is estimated to average 0.20 hours per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of the requested information. Comments regarding the accuracy of this burden estimate and any suggestions for reducing this burden can be sent to: U.S. Department of Housing and Urban Development, Office of the Chief Data Officer, R, 451 7th St SW, Room 8210, Washington, DC 20410-5000. Do not send completed forms to this address. This Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a valid OMB control number. This Agency is authorized to collect this information under Section 102 of the Department of Housing and Urban Development Reform Act of 1989. The information you provide will enable this Agency to carry out its responsibilities under this Act and ensure greater accountability and integrity in the provision of certain types of assistance administered by this Agency. The information collected via this form is required to obtain the benefit sought in the grant program. Failure to provide any required information may delay the processing of your application and may result in sanctions and penalties including the administrative and civil money penalties specified under 24 CFR §4.38. This information will not be held confidential and may be made available to the public in accordance with the Freedom of Information Act (5 U.S.C. §552). The information collected via this form is not retrieved by a personal identifier, therefore it does not meet the threshold for a Privacy Act Statement.

Type or clearly print the following information.

****Warning:** *Anyone who knowingly submits a false claim or makes a false statement is subject to criminal and/or civil penalties, including confinement for up to 5 years, fines, and civil and administrative penalties (18 U.S.C §§ 287, 1001, 1010, 1012, 1014; 31 U.S.C. § 3729, 3802; 24 CFR § 28.10(b)(1)(iii)).*

Applicant Organization: Columbia, Hamilton, Lafayette and Suwannee Counties CoC

Assistance Listing number and Federal Program name to which the Applicant is applying:

Include the funding opportunity number and name exactly as it appears in the applicable funding opportunity announcement (example: 14.896, Family Self-Sufficiency Program).

14.267 HUD Community Planning and Development

Opportunity Zone Census Tract(s), which the proposed activities/projects will benefit:

Include below the full 11-digit census tract number (example: 06067001101). Designated Opportunity Zone Census Tracts can be found at: <https://opportunityzones.hud.gov/resources>. Select the "CDFI Fund Opportunity Zones Resources" link and then select the "List of designated Qualified Opportunity Zones."

12023110300 , 12121970200, 12067960202, 12047960103

The application meets which of the following criteria (please select one):

- ☐ The proposed activities/projects will occur solely within the Opportunity Zone Census Tract(s) listed above.
- ☒ The proposed activities/projects will occur within the Opportunity Zone Census Tract(s) listed above and other communities.
- ☐ The proposed activities/projects will occur outside Opportunity Zone Census Tracts, but substantial and direct benefits will accrue within the Opportunity Zone Census Tracts listed above.

Note: Projects which substantially and directly benefit Opportunity Zone Census Tracts, but which do not consist of activities delivered within Opportunity Zone Census Tracts may be considered for competitive preference. If applicable, the respective Federal Agency will clearly define "substantially and directly" in the relevant funding announcement.

Estimated Funding Allocations

Estimate a percentage of the total dollar amount of federal funding awarded that would result in a direct benefit within the Opportunity Zone Census Tracts listed above:

- ☐ 76% - 100%
- ☐ 51% - 75%
- ☒ 26% - 50%
- ☐ 11% - 25%
- ☐ 1%- 10%

Provide a narrative explaining and/or reference the section in the application that explains how the project will support public and private investment in urban and economically distressed areas, specifically qualified Opportunity Zones (300-word limit):

Example: "The Main Street project described in this application will stimulate economic opportunity and mobility, encourage entrepreneurship, expand quality educational opportunities, and promote workforce development for those families residing within the XYZ Opportunity Zone."

The HUD RR, Launch, CC RR and Another Way Home and other CPD programs described in this application will stimulate economic stability and mobility, prevent housing displacement, expand access to safe and affordable living conditions, and promote long-term financial security for those families residing within the Columbia, Hamilton, Lafayette and Suwannee Opportunity Zones

Check the following boxes that accurately reflect the nature or purpose of the proposed project:

- | | |
|---|---|
| ☐ Access to Capital | ☐ Workforce Development |
| ☐ Asset Building | ☐ Low Income Housing Tax Credit (LIHTC) or other rent restricted housing |
| ☐ Business Assistance | ☐ Market rate housing |
| ☐ Community Capacity Building | ☐ Industrial development |
| ☐ Economic Development | ☐ Commercial or retail development |
| ☐ Education | ☐ Other business development |
| ☐ Healthy Food Access | ☐ "Above ground" infrastructure — streets, sidewalks, lighting |
| ☐ Health | ☐ "Below ground" infrastructure — water, sewer, gas, electric |
| ☒ Housing | ☐ Schools or other educational facilities |
| ☒ Human Services and Family Support | ☐ Hospitals or other health care facilities |
| ☐ Community Infrastructure | |
| ☐ Public Safety | |

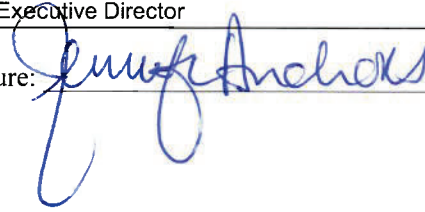
Certification of Authorized Representative for the Applicant:

****Under penalty of perjury, I certify on behalf of the Applicant that**

- (1) all information provided on this form is true, complete, and accurate, and
- (2) the Applicant will notify the Agency immediately upon learning of any change in the information provided on this form, and
- (3) I am authorized to speak for the Applicant regarding all information provided on this form.

Prefix: _____ First Name: Jennifer _____ Middle Initial: _____ Last Name: Anchors _____ Suffix: _____

Title: Executive Director _____ Organization: United Way of Suwannee Valley _____

Signature:  _____ Date: 09/28/2026 _____