

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: NY-513 - Wayne, Ontario, Seneca, Yates Counties CoC

1A-2. Collaborative Applicant Name: Finger Lakes Area Counseling & Recovery Agency (FLACRA)

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Finger Lakes Area Counseling & Recovery Agency (FL

1B. Coordination and Engagement–Accountable Structure and Participation

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

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

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

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

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

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

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

(limit 2,500 characters)

CoC NY-513 is comprised of the Finger Lakes Housing Consortium (FLHC) and the CoC Board. Four counties (Wayne, Seneca, Ontario, Yates) in the CoC geographic area have Housing Consortia where CoC information and issues are shared as a standard agenda item. Finger Lakes Area Counseling and Recovery Agency (FLACRA) is the lead agency for the CoC.

The CoC does not conduct a specific membership campaign; rather, its membership enrollment is ongoing throughout the year. Membership is inclusive and open to any individual or organization with an interest in addressing and eradicating homelessness in our community. We actively welcome participants from diverse sectors, including businesses, faith-based and secular organizations, law enforcement, individuals with disabilities, and representatives from various cultural backgrounds. All communications related to membership are distributed via email to current members, comprising over 80 community-based organizations across the four counties served by the CoC.

The Executive Committee conducts a semi-annual membership review to ensure comprehensive geographic representation and maintain a diverse range of expertise and systems knowledge. A dedicated CoC page is also available on the FLACRA website and social media pages, where all relevant CoC information is regularly shared and accessible to the public.

The CoC effectively communicates with individuals with disabilities via email, phone, and TTY. Documents are shared via email, and key documents can be found on the CoC website. All documents are posted in PDF format.

As a predominantly rural CoC covering a four-county area, we have limited organizations dedicated to serving a single population group. Instead, our member organizations are sensitive to and are experienced in addressing the needs of marginalized communities. While some organizations focus on specific populations, such as the Family Counseling Center of the Finger Lakes, an active CoC member, the emphasis is generally on inclusive service delivery. The Family Counseling Center, for example, brings valuable expertise in working with individuals and families, contributing their unique insights to our strategic planning, training initiatives, and other collaborative efforts.

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

CoC membership is open to anyone within the CoC geographic area interested in addressing homelessness issues in our CoC. The CoC Board proactively recruits members with expertise in specific subpopulations/related fields such as law enforcement, mainstream benefits, medical, housing, and persons with lived experience. The Executive Committee reviews membership semi-annually to ensure adequate & fair representation from all four counties in the CoC geography. Meeting announcements are widely shared via listservs, websites, and social media pages, and Agendas are sent with each meeting announcement. Meeting facilitators frame topics and often solicit an expert in the field to further the discussion. Input from all members is considered for all decisions made.

Four (4) Housing Consortia represent each of the four counties within the CoC. Each consortium sends at least one representative to the CoC full membership meetings. They are actively involved in the planning process to end homelessness in the CoC, and each brings their unique perspective and housing expertise to the table, i.e., ongoing discussions of the need for more eviction prevention funding, extending housing assistance, and landlord

engagement. Agendas and minutes of CoC meetings are widely distributed via the CoC email list, including member and non-member agencies. Standard agenda items include update reports from community groups and CoC Committees. Attendance at the four Housing Consortia has grown resulting in local community-based organizations that serve sub-populations; i.e. - reentry, substance use disorders, behavioral health, developmentally disabled, youth, etc., joining the county housing consortia.

The CoC effectively communicates with individuals with disabilities via email, phone, and TTY. Documents are shared via email, and key documents are posted to the CoC page on the FLACRA website.

CoC Board members and stakeholders participate in many task forces, community forums, committees, etc. outside of the CoC meetings/activities. These are systems intimately related to homelessness such as chemical dependency and mental health, which ensure that the needs of the homeless are brought to the attention of all sectors of the community. This has led to partnerships that have pursued funding opportunities outside the CoC. This has been particularly successful in creating new affordable and permanent housing units, which are units set aside for the home

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

(limit 2,500 characters)

The CoC conducts outreach to organizations that have not previously received CoC Program funding through county Housing Consortium meetings, Finger Lakes Housing Consortium meetings, direct email distribution to CoC membership, social media, press releases, and targeted outreach to community organizations that may be eligible to apply. The CoC funding process is also discussed at Housing Consortium and CoC membership meetings throughout the year to ensure organizations are aware of funding opportunities and the application process.

For the FY 2026 competition, applications opened on June 30, 2026. The funding opportunity and application materials were posted on social media and distributed by email to CoC membership. A press release announcing the funding opportunity was issued on July 6, and an informational webinar was held on July 7 to review the funding opportunity, application requirements, and process and provide organizations an opportunity to ask questions. New project applications were due July 15, 2026, by 5:00 p.m.

The CoC also seeks to expand participation by organizations that have not previously received CoC Program funding. For FY 2026, FLACRA is the only current CoC-funded agency eligible to continue receiving funding under this year's NOFO. Wayne CAP, a longstanding CoC-funded provider, is not eligible for renewal due to changes in the FY 2026 NOFO related to rental assistance project eligibility, rather than project performance. Recognizing the importance of maintaining a diverse provider network, NY-513 will make a concerted effort in FY 2027 to individually contact organizations serving specialized populations, including domestic violence survivors, youth, and other underserved populations, to encourage submission of applications in addition to broadly advertising the funding opportunity.

Renewal and new project applications are reviewed and scored by the CoC Board using established scoring criteria provided at the beginning of the application process and made available with the RFP and application materials. Each Committee member independently scores each application, scores are averaged, and projects are ranked based on the established criteria. Projects are submitted to HUD in ranked order within the CoC's available funding. New applicants are subject to the same transparent review and ranking process as existing CoC-funded organizations.

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)

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

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

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

1C. Coordination and Engagement

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1C-1.	Treatment and Recovery Services—On-site Substance Use Treatment Availability.	
	You must upload the List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment attachment to the 4A. Attachments Screen.	
	What percent of your TH/RRH/PSH projects have substance use treatment available on site?	100%

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)

Substance use treatment is available on site for 100% of NY-513's TH/RRH/PSH projects included in this question. FLACRA, the CoC's lead agency and a regional behavioral health provider with more than 50 years of experience, delivers and coordinates treatment and recovery services that are accessible to program participants where they live and receive housing supports.

Services include assessment, diagnosis, treatment planning, relapse prevention planning, wellness recovery action planning, individual and group counseling, peer recovery services, case management, and referrals to additional levels of care as needed. FLACRA's Mobile/Crisis Mobile Clinic and outreach clinicians expand access across the CoC's rural four-county geography by bringing addiction treatment, mental health services, crisis support, and health-related services directly to participants, including those in scattered-site or apartment-based housing.

FLACRA uses evidence-based and recovery-oriented interventions, including Motivational Interviewing, Stages of Change, Decision Making, Commitment to Change, and Living in Balance. Services are individualized based on participant need and are designed to reduce barriers to treatment engagement, support recovery, and promote housing stability.

Participants may also be connected to vocational rehabilitation, prevocational services, CORE services, peer support, care coordination, and other community-based resources. This integrated model ensures that substance use treatment is available to TH/RRH/PSH participants, supports continued engagement in services, and aligns with the NOFO priority of connecting people experiencing homelessness with treatment, recovery supports, and stable housing.

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)

FLACRA, the lead applicant for NY-513, is the largest behavioral health provider in the four-county region and provides outpatient treatment for mental health and substance use disorders. FLACRA offers a broad continuum of treatment, crisis support, and recovery services, including psychosocial interventions; evidence-based practices such as Commitment to Change and Dialectical Behavior Therapy; family and children's therapy; group and individual therapy; Intensive Outpatient Services; peer recovery supports; medication management for mental health disorders; Medications for Addiction Treatment, including MOUD such as methadone, buprenorphine, and naltrexone; and Medications for Alcohol Use Disorder. FLACRA has received three SAMHSA expansion grants for the Certified Community Behavioral Health Clinic model of care, implemented locally through FLACRA One-stop Wellness Centers, which include mental health care, addiction treatment, health-related services, targeted case management, and peer recovery services.

FLACRA also supports suicide prevention through its crisis hotline, 1-833-4-FLACRA, peer crisis support services, Zero Suicide training, and referrals to CPEP, 988, and 911 when clinically appropriate. The CoC also partners with community providers such as Lakeview Health Services, Family Counseling of the Finger Lakes, and Wayne Behavioral Health Clinic, all of which provide mental health or addiction treatment services and participate in CoC planning, housing consortium work, and service coordination. The CoC also coordinates with law enforcement and Crisis Intervention Teams, including partners in Ontario County, to support crisis intervention and connect individuals to behavioral health care, recovery supports, and housing-related services. FLACRA also offers Mobile Clinical Services, In-Community Services, Detoxification, Inpatient Stabilization and Rehabilitation, and Reintegration levels of treatment.

The benefit of FLACRA being the lead applicant for NY-513 and the largest behavioral health provider in the region is its ability to streamline services and refer residents to our own internal services, as well as partnerships with agencies that we have established relationships with for services that we do not provide.

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)

FLACRA provides Peer Recovery Supports and services and is one of the largest Recovery Support services in New York State. The organization received national accreditation through CPRSS and uses fidelity to the model of recovery. Peer Recovery and Peer Recovery Advocates provide a level of engagement and outreach, using motivational interviewing, stages of change, recovery capital index scale, WRAP planning, and more to engage, continue to motivate towards recovery, and assisting with linkages, referrals, groups, Recovery Center attendance, etc. Our Recovery Centers offer services closely linked with social service providers, CoC connected providers and community, connectivity with law enforcement, probation and other entities to work in tandem with remaining in treatment and recovery services. Peer Recovery and advocacy efforts are an essential evidence base practice and are embedded in each level of care, including outpatient, residential, housing services, vocational and educational services, and other modalities of treatment at FLACRA.

These services and support are critical for assuring people have support to continue to navigate into treatment. We operate 3 Recovery Community Centers in Ontario, Seneca and Yates Counties, A Youth Clubhouse in Wayne County, and a Peer Crisis Support In-Community program, connected to the Outpatient services. Many of the Peers that FLACRA employs are working to obtain certification as CRPAs (Certified Recovery Peer Advocate) or are working towards other credentialing such as NYCPS and other forms of services and treatments in the efforts of providing peer recovery and peer advocacy services at every juncture. Peers are an excellent service to ensure continued navigation towards treatment and recovery.

The CoC also partners with many other companies offering Peer Recovery Services and supports such as The Partnership for Ontario County and Wayne Behavioral Health Services. Services and resources from various providers are pushed in for many of the housing providers and medical providers in the community.

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

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

(limit 2,500 characters)

The CoC and four-county housing consortium has multiple partners serving specifically individuals with Serious Mental Illness. Partners such as Lakeview Health Services and their Prospect House Crisis Stabilization and transitional housing services program have been an exceptional partner in promoting opportunities for stabilizing people with Serious Mental Illness. Eagle Star Housing also provides similar services as well as FLACRA, for veterans and other individuals needing crisis and transitional housing stability. There are many other providers among the CoC continuum of care that work together with Assertive Community Treatment teams, Single Point of Access network, CPEP, FLACRA Crisis supports and Mobile Clinic, Wayne Behavioral Health Open Access, Helio Health SOS teams, FLACRA's GBHI SAMHSA grant, and other partner services using a coordinated system of care for immediate referral and access to care for those experiencing Serious Mental Illness.

These CoC partners and many more services are among a closely connected delivery system of services in the four-county region using Intensive coordination and assertive outreach with comprehensive treatment, additional referrals and linkages are all part of assuring the community is receiving and has immediate access to long-term treatment for individuals experiencing Serious Mental Illness.

FLACRA provides Peer Advocacy Services specifically focused on the Coordinated Entry list which is created through the HMIS system. All providers, including each county Department of Social Services, enter each person who is homeless into the HMIS system and coordinated entry list, identifying those experiencing Serious Mental Illness using VI-SPIDAT screening tool. The Peer Advocate actively visits the individual or family to continually assure connectivity, and coordinates referrals and linkages throughout the four counties to stabilize, offer immediate treatment access for Serious Mental Illness.

The partners and the CoC hold a multitude of MOUs and service Linkage agreements to directly support coordination and referrals to provide immediate access to care.

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)

NY-513's lead agency, FLACRA, maintains direct partnerships with Drug Courts across all four CoC counties and participates with Mental Health Courts where available. FLACRA provides behavioral health treatment and recovery services, participates in multidisciplinary court team meetings, and coordinates with court personnel, treatment providers, and peer advocates to support individuals with mental health and substance use disorders.

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)

FLACRA holds direct contracts with Drug Courts in all four NY-513 counties and works closely with Drug Court teams, judges, probation departments, and other treatment providers. FLACRA participates in weekly Drug Court treatment team meetings across the four counties, allowing for direct coordination regarding treatment participation, progress, barriers, and service needs. FLACRA also participates in Mental Health Courts where available and provides clinical treatment and Peer Advocacy services supporting engagement, attendance, and adherence to court requirements.

FLACRA directly links individuals involved with specialty courts to appropriate levels of substance use and mental health treatment and supportive services. Court orders and community supervision plans are incorporated into individualized treatment and recovery planning. FLACRA maintains direct communication with courts, probation, and parole while using evidence-based clinical practices, motivational interviewing, peer support, and stages-of-change approaches to help individuals understand and meet court requirements.

Coordination extends beyond treatment to address factors affecting housing stability and independence. Individuals are connected, based on need, to care management, peer recovery services, transitional and other housing resources, benefits, and vocational rehabilitation and employment services. These supports help individuals build recovery capital, increase income and self-sufficiency, maintain treatment engagement, and obtain and retain stable housing.

FLACRA and Lakeview Health Services also serve individuals subject to Assisted Outpatient Treatment (AOT) and involuntary civil commitment. They coordinate with county partners, Single Point of Access (SPOA), treatment providers, and other involved systems to implement court-ordered treatment and supervision plans. Care management, clinical services, and peer advocacy support adherence while addressing behavioral health, housing, and other community-based needs, with the goal of increasing stability and supporting successful community tenure.

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)

NY-513 partners FLACRA and Lakeview Health Services maintain MOUs and direct connections with 988 and local crisis systems across the four-county CoC. FLACRA provides 24/7 peer crisis response, mobile outreach, immediate access to treatment, and detoxification/stabilization services. Lakeview provides crisis stabilization, respite, and transitional services. Partners coordinate with 988, hospitals, CPEP, law enforcement, and county DCSs.

1C-1f.	Treatment and Recovery Services—Availability of Units for Persons Reporting Chronic Substance Use.	
	You must upload the List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment attachment to the 4A. Attachments Screen.	
	Identify the number of CoC Program-funded units that require program participant engagement in substance abuse treatment services as a condition of continued participation in the program in accordance with 24 CFR 578.75.	0

1C-1g.	Treatment and Recovery Services—24/7 Access to Detox, Residential, or Inpatient Treatment.	
Is there 24/7 access to detox, residential, and inpatient behavioral health treatment within the geographic area of your CoC?		Yes

1C-1h. Treatment and Recovery Services—Formal Partnership with Behavioral and Mental Health Facilities.

Identify at least one formal partnership the CoC has with a Certified Community Behavioral Health Clinic (CCBHC), Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GBHI) provider, or a similar facility if none of the above are located in the geographic area.

(limit 500 characters)

FLACRA has received SAMHSA expansion grants and is designated by New York State to operate two CCBHCs, one in Ontario County and one in Yates County. The CCBHCs provide nine elements of integrated care. FLACRA also operates the SAMHSA-funded GBHI program across all four CoC counties, providing benefits enrollment, treatment, care coordination, and housing coordination for people experiencing homelessness. Referrals are accepted from all CoC providers.

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)

NY-513 does not currently have a new or existing CoC Program-funded project that operates sober housing in accordance with 24 CFR 578.93(b)(5). The CoC does maintain referral relationships with community-based recovery housing providers, including Recovery Homes of Rochester, to connect individuals seeking sober living environments with available resources.

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

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

(limit 2,500 characters)

The CoC has multiple providers that offer warm hand-offs to stable housing providers. This includes Finger Lakes Wayne CAP, Lakeview Health Services, Wayne Behavioral Health Services, FLACRA, and several other behavioral health providers in the region. Through the Coordinated Entry list, Peer Advocacy services are employed to ensure connectivity to each person who is currently homeless.

When there are available housing opportunities with the programs funded throughout the CoC, this person remains consistent and present to ensure connectivity to the program staff that is making placements into the funded housing. This consistent and careful engagement approach of warm handoffs significantly reduces barriers to achieving housing transitions to stable housing. The funded CoC housing provider works closely with both the Coordinated CoC Peer Advocate and many other providers who are also involved, such as case managers, probation officers, other peer advocates, and referral entities.

This comprehensive coordinated approach includes service planning to continue necessary coordination of resources, services, and other linkages that reduce disengagement and detachment to the service planning and services needed to create vocational opportunities, treatment, and other services necessary for the person to stay engaged and significantly reduce entry back to homelessness. The CoC-funded programs, as well as other providers, use motivational interviewing and stages of change to continue the focus on long-term recovery, success in independent living, and achieving economic self-sufficiency.

1C-2.	Supportive Services Investment.	
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1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	
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Number

\$597,892

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.	\$72,996
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	12%
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.	\$62,838
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).	23%

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)

NY-513 does not receive a direct Emergency Solutions Grants (ESG) allocation because the CoC's four-county rural geographic area does not include an ESG entitlement jurisdiction. The CoC coordinates with the New York State Office of Temporary and Disability Assistance (OTDA), the applicable state partner, regarding homelessness planning and services.

NY-513 provides HMIS data used to inform homelessness planning and completes Homeless Services Plans for each of the four counties within the CoC geographic area, Ontario, Seneca, Wayne, and Yates. Through this process, the CoC works with county Departments of Social Services and OTDA to identify homelessness needs, review available data and outcomes, and coordinate homelessness services and resources.

NY-513 will continue coordinating with OTDA and the four county Departments of Social Services through HMIS reporting, Homeless Services Plans, and ongoing homelessness planning to ensure state and local resources are informed by identified needs and coordinated with the broader CoC homelessness response system.

1C-4a. Coordination with Emergency Shelter Providers.

Describe how your CoC coordinates with shelter providers to connect individuals and families with CoC assistance.

(limit 2,500 characters)

NY-513 does not have traditional emergency shelters; however, domestic violence shelters operate within the CoC geographic area. For individuals and families experiencing homelessness who are not fleeing domestic violence, the County Departments of Social Services (DSS) utilize hotel/motel placements to provide emergency housing.

NY-513 coordinates closely with DSS and domestic violence shelter providers to connect individuals and families experiencing homelessness to Coordinated Entry (CE), CoC-funded housing, and other housing and supportive services. A key component of this coordination is a Coordinated Entry Peer located within DSS. The Peer engages individuals and families seeking emergency housing assistance, connects households to CE, identifies housing and service needs, assists with navigating available resources, and supports movement toward permanent housing. This provides a direct connection between individuals presenting for emergency housing assistance and the CoC's housing and service system.

Coordination also occurs through the County Housing Consortia and Homeless Advisory Committee, where DSS, housing and behavioral health providers, domestic violence providers, and other community partners participate. These partnerships help identify emerging needs and barriers, coordinate available housing and supportive services, and strengthen pathways from emergency housing to permanent housing.

For survivors of domestic violence, NY-513 coordinates with victim service providers to ensure access to confidential, trauma-informed housing and services while protecting survivor information.

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)

NY-513 uses PIT, HIC, HMIS, and System Performance Measure (SPM) data to inform state and local government partners about the scope and characteristics of homelessness, available housing resources, system utilization, and performance across Ontario, Seneca, Wayne, and Yates Counties. Data are shared in accordance with the HMIS Privacy Plan and applicable federal, state, and local privacy requirements.

The CoC shares aggregate homelessness data and system trends with county Departments of Social Services, county and municipal government, public health, behavioral health and other governmental partners through CoC membership and Board meetings, County Housing Consortium meetings, community planning activities, funding applications, and other cross-system planning efforts. PIT and HIC results provide information regarding sheltered and unsheltered homelessness and the inventory and utilization of housing resources. HMIS and SPM data are used to examine trends including the length of time individuals remain homeless, returns to homelessness, first-time homelessness, successful housing outcomes, income growth, and other system performance indicators.

NY-513 uses these data with government and community partners to identify service gaps, evaluate housing and supportive-service needs, inform resource and funding decisions, strengthen prevention and diversion strategies, and identify opportunities to improve movement from homelessness to permanent housing. County-level discussions also allow partners to consider local trends and service needs within each of the four counties while maintaining a CoC-wide understanding of system performance.

The CoC's HMIS policies govern data use and disclosure. Client-level information is protected, and data released beyond permitted HMIS uses are provided in aggregate and must be anonymous, with identifiers and information that could be used to infer an individual or household's identity removed. This allows NY-513 to provide state and local government partners with meaningful homelessness and performance information while protecting participant privacy.

The CoC will continue using PIT, HIC, HMIS, and SPM data as part of ongoing CoC and county-level planning to evaluate trends, monitor performance, identify emerging needs, and support data-informed improvements to the homelessness response system.

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)

NY-513 uses multiple data sources alongside HMIS to identify service gaps, improve care coordination, and address factors contributing to housing instability. FLACRA, Lakeview Health Services, Wayne Behavioral Health, County Departments of Social Services (DSS), law enforcement, and other community providers contribute data and system-level information through collaborative planning groups and community needs assessments.

Behavioral health providers use electronic health record and state data systems, including 10e11, OASAS Client Data Systems, NYS PSYCKES, Regional Health Information Organization (RHIO) data, and available health care claims data. These sources provide information on admissions, discharges, emergency department and inpatient utilization, treatment engagement, follow-up care, and other outcomes. RHIO notifications can also alert authorized providers to emergency department visits and hospitalizations, allowing for timely outreach, reassessment of treatment and service plans, and coordination of needed supports.

Data are reviewed through community partnerships including Behavioral Health Care Collaboratives, county-level planning groups, law enforcement partnerships, Systems of Care, CCBHC advisory structures, and other community needs assessment and quality-improvement initiatives. These partnerships allow health, behavioral health, social service, housing, and other systems to identify trends and gaps that may not be visible through HMIS alone.

For example, PSYCKES, RHIO, EHR, and claims data help providers monitor measures such as access to care, follow-up after hospitalization or emergency department use, treatment engagement, and initiation of medication for addiction treatment. When considered alongside HMIS and Coordinated Entry data, these measures help NY-513 identify where behavioral health needs, gaps in treatment engagement, repeated crisis-system utilization, and housing instability intersect.

Findings are used to strengthen referral pathways, improve transitions between levels of care, coordinate behavioral health and housing supports, and identify opportunities for earlier intervention. Combining HMIS with health, behavioral health, social service, law enforcement/corrections, and community-level data provides a broader understanding of system needs and informs CoC planning and resource coordination.

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)

NY-513's lead agency and Collaborative Applicant, FLACRA, maintains formal partnerships with the Finger Lakes Workforce Investment Board and Ontario County Workforce Development to connect individuals experiencing homelessness with employment, workforce development, job readiness, and training opportunities. These partnerships support referrals and coordination with local workforce resources and employment services.

FLACRA also operates an OASAS-funded Vocational Rehabilitation program in partnership with NADAP, which provides specialized employment and job development services to individuals receiving behavioral health and recovery services. The program assists individuals with identifying employment goals, developing job readiness skills, connecting with employers, and obtaining and maintaining competitive employment.

The CoC also collaborates with Departments of Social Services across Ontario, Seneca, Wayne, and Yates Counties, which provide and coordinate employment and workforce services for eligible individuals and families. Through these partnerships, individuals experiencing homelessness can be connected with employment supports, benefits, training, and other resources designed to increase income and support housing stability.

In addition, CoC partners coordinate with local education providers, including Finger Lakes Community College and Keuka College, to connect individuals with education, training, and career pathways when appropriate. Together, these partnerships provide multiple access points for individuals experiencing homelessness to obtain employment, education, vocational rehabilitation, and workforce development services based on their individual needs and goals.

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)

NY-513 serves a four-county rural area where individuals experiencing unsheltered homelessness are often geographically dispersed. The CoC relies on coordination among outreach providers, law enforcement, first responders, hospitals, county agencies, and community partners to identify and engage individuals who may otherwise be difficult to connect with services.

Law enforcement is directly represented in CoC planning through the Geneva City Police Department and Wayne County Sheriff's Office serving on the NY-513 CoC Board. Their participation strengthens communication, referral pathways, and connections to housing and supportive services.

FLACRA's COTI Outreach and Engagement Team provides mobile, community-based outreach and crisis response. Local law enforcement can contact COTI during substance use-related crises, including overdoses. COTI staff provide peer and clinical support, assess immediate needs, and connect individuals to substance use disorder treatment, recovery supports, Coordinated Entry, housing, healthcare, benefits, and other services. This provides first responders with a service-based response option and creates opportunities for continued engagement after the immediate crisis.

FLACRA also contracts with the University of Rochester to provide hospital-based peer services in the emergency departments at Geneva General Hospital and Soldiers & Sailors Memorial Hospital in Penn Yan. Peers engage individuals during a critical point and connect them to treatment, recovery resources, housing, and community-based services.

The CoC also maintains formal relationships with jail, probation, and public health partners that support referrals, communication, coordinated services, and continuity of care.

Through law enforcement participation in CoC governance, COTI crisis response, hospital-based peer engagement, cross-system referrals, and community outreach, NY-513 works to increase positive interactions, build trust, and increase engagement with housing, treatment, recovery, and other CoC services.

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)

NY-513 and its recipient agencies incorporate family and natural support networks into housing and service planning when appropriate and desired by the individual or family experiencing homelessness. Through Coordinated Entry, care management, peer services, and CoC-funded programs, staff work with individuals to identify family members, friends, and other natural supports who may provide safe housing, emotional support, transportation, or other assistance that can help resolve homelessness and support long-term housing stability.

When reunification is identified as a safe and appropriate option, staff assist with contacting family or support persons, facilitating conversations, addressing barriers to reunification, and coordinating the transition. Assistance may include transportation planning, arranging or helping access travel assistance, obtaining identification or other documents needed for travel, coordinating medications and treatment needs, and connecting the individual with services and benefits in the receiving community.

When a family or support network is located outside the CoC geographic area, providers coordinate with agencies, housing resources, behavioral health providers, social services, and other community supports in the receiving area to promote continuity of care and reduce the risk of a return to homelessness. Case managers and peers may assist with referrals and warm handoffs and confirm that appropriate supports are available before transition whenever possible.

Reunification is individualized and voluntary and is pursued only when it supports the participant's safety, housing stability, and goals. For individuals for whom family reunification is not appropriate or desired, providers assist in strengthening other natural and community-based support networks. These efforts help individuals build lasting connections and supports that can continue beyond formal CoC-funded services and contribute to long-term housing stability and independence.

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)

NY-513 cooperates with local law enforcement, first responders, county governments, behavioral health providers, and community partners to advance public safety while connecting individuals experiencing homelessness to housing, treatment, and supportive services. The CoC does not interfere with lawful local efforts related to public illicit drug use, individuals presenting a danger to themselves or others, encampments, or sex-offender registration requirements.

Large homeless encampments are not typically present within NY-513's rural geographic area. If an encampment or individual experiencing unsheltered homelessness is identified, the CoC and its partners cooperate with local authorities and focus on connecting affected individuals to Coordinated Entry, emergency housing resources, behavioral health and substance use treatment, peer services, and other supports.

NY-513 has strong coordination between behavioral health providers, law enforcement, and first responders related to substance use and overdose response. Law enforcement may call FLACRA's COTI team to respond during an overdose crisis, providing an immediate connection to substance use treatment, peer support, and other recovery services. FLACRA also works closely with Drug Courts, probation, and other justice-system partners to connect individuals to treatment and supports.

For individuals presenting a danger to themselves or others, behavioral health providers coordinate with law enforcement, hospitals, county mental health systems, SPOA, Assisted Outpatient Treatment (AOT), and other appropriate systems. FLACRA and Lakeview Health Services serve individuals subject to AOT and involuntary civil commitment and coordinate treatment and community-based supports to promote stability and adherence to court-ordered plans.

New York has not been determined by DOJ to have substantially implemented federal SORNA and instead operates under New York's Sex Offender Registration Act (SORA). NY-513 does not administer the registry but cooperates with law enforcement and applicable registration requirements. Providers may use publicly available registry information to assist participants in identifying legally permissible housing and supporting discharge or reentry planning while maintaining confidentiality as required by law.

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)

NY-513 is a predominantly rural four-county CoC where large or established homeless encampments are not typically present. The CoC does not own or control public property and does not have authority to clear tents or encampments. Authority rests with the applicable municipality, county, law enforcement agency, or public property owner pursuant to applicable local laws and policies governing public property, trespass, sanitation, and public safety.

Beneficial local practices include established coordination among County Departments of Social Services (DSS), law enforcement, behavioral health providers, the CoC, and other community partners. NY-513 will leverage these relationships when individuals are identified living outdoors by connecting them to Coordinated Entry (CE), DSS emergency hotel/motel placement when eligible, behavioral health and substance use treatment, benefits, transportation, and other housing and supportive services.

Because encampments are uncommon, NY-513's approach focuses on rapid coordination when an unsheltered location is identified rather than maintaining a dedicated encampment-response system. Restrictive factors include the CoC's rural geography, limited public transportation, lack of traditional emergency shelters, and limited housing availability. To mitigate these barriers, the CoC will use existing county partnerships to facilitate early notification, coordinate outreach and service connections, identify available emergency and permanent housing resources, and support follow-up after individuals relocate.

The 2026 PIT Count identified 5 unsheltered persons in NY-513. Qualitative feedback from County Housing Consortia and community partners indicates that unsheltered homelessness generally occurs in scattered locations rather than large, organized encampments. NY-513 will continue using PIT, CE, and partner information to identify unsheltered homelessness and coordinate an appropriate service response while cooperating with lawful local public safety actions.

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)

NY-513 encompasses the predominantly rural counties of Ontario, Wayne, Seneca, and Yates. Large, concentrated homeless encampments are not typically present within the CoC. Unsheltered homelessness does occur, but individuals are more commonly identified in scattered locations or places not intended for habitation rather than established multi-person encampments.

The 2026 Point-in-Time (PIT) Count identified 5 individuals experiencing unsheltered homelessness across NY-513. Because the PIT Count represents homelessness on a single night and is not an inventory of tents or encampments, NY-513 also relies on Coordinated Entry, County Departments of Social Services, law enforcement, behavioral health providers, County Housing Consortia, and other community partners to identify emerging locations and needs throughout the year.

NY-513 does not currently maintain a separate real-time inventory of tents or encampments because established encampments are uncommon within the geographic area. When an individual or small group is identified living outdoors or in another location not intended for habitation, partners work to connect them to Coordinated Entry, DSS emergency housing resources, behavioral health and substance use treatment, benefits, and available permanent housing resources.

The CoC will continue monitoring PIT and Coordinated Entry data and information from county and community partners to identify changes in unsheltered homelessness and determine whether additional outreach or encampment-specific strategies become necessary.

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)

New York's 911 Good Samaritan Law and local coordination among law enforcement, EMS, hospitals, county behavioral health systems, and OASAS-certified providers support rapid overdose response and connection to treatment. NY-513 leverages these practices while recognizing law enforcement's independent authority to address illegal conduct and immediate threats to public safety.

A key local practice is coordination between law enforcement and FLACRA's COTI team. Law enforcement can request COTI response during an overdose crisis, creating an immediate pathway from a public-safety or medical encounter to substance use treatment, peer recovery support, and other services. Providers also coordinate with EMS, hospitals, Drug Courts, probation, and community partners to connect individuals to appropriate levels of care.

NYSDOH data demonstrate the need for this response. In 2025, Ontario, Seneca, Wayne, and Yates Counties recorded 13 opioid overdose deaths. Law enforcement reported 27 naloxone administrations across the four counties, including 12 each in Ontario and Wayne Counties. In addition, 922 unique individuals were enrolled in OASAS-certified SUD treatment programs in 2025 reporting an opioid as their primary substance at admission.

Barriers include rural geography, transportation limitations, treatment capacity, housing instability, and reluctance to engage in treatment. NY-513 mitigates these barriers through COTI, peer engagement, overdose-prevention resources, and connections to treatment, housing, benefits, and transportation. When drug use presents an immediate medical or safety emergency, providers coordinate with 911/EMS and law enforcement. NY-513 will continue using NYSDOH, treatment, CE, and partner data to identify trends and strengthen rapid connections from crisis to treatment and housing.

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

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

(limit 2,500 characters)

Overdose and illicit drug use remain public-health and public-safety concerns across Ontario, Wayne, Seneca, and Yates Counties. NYSDOH's July 2026 County Opioid Quarterly Report documents 13 opioid overdose deaths across the four counties in 2025: 6 in Ontario, 6 in Wayne, 1 in Yates, and 0 in Seneca. Law enforcement reported 27 naloxone administrations during 2025, including 12 in Ontario, 12 in Wayne, 2 in Seneca, and 1 in Yates.

The same report demonstrates substantial demand for treatment. In 2025, 922 unique individuals across the four counties were enrolled in OASAS-certified substance use disorder treatment programs and reported an opioid as their primary substance at admission.

Available data do not consistently identify whether an overdose or illicit drug use occurred in a public space, private residence, hotel/motel, vehicle, or other location. HMIS likewise is not an overdose or law-enforcement surveillance system. NY-513 therefore cannot reliably quantify the subset of overdose or illicit drug-use incidents occurring specifically in public spaces.

Local partners nevertheless respond to substance-use crises throughout the region. FLACRA's COTI team coordinates with law enforcement during overdose crises to rapidly engage individuals and connect them to treatment, peer recovery services, and other supports. NY-513 uses NYSDOH surveillance data and information from law enforcement, EMS, behavioral health providers, hospitals, and community partners alongside HMIS and CE data to identify trends, service gaps, and opportunities to strengthen connections to treatment, recovery supports, and housing.

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)

New York Mental Hygiene Law (MHL) Article 9 establishes standards and authorized processes for emergency psychiatric assessment and involuntary admission. Under MHL, “likelihood to result in serious harm” includes substantial risk of physical harm to self or others and, under applicable circumstances, substantial risk resulting from an inability or refusal due to mental illness to meet essential needs such as food, necessary medical care, personal safety, or shelter. Authorized entities, including law enforcement, county Directors of Community Services (DCS), and qualified clinicians acting within their statutory authority, may facilitate emergency assessment and transport when applicable criteria are met.

NY-513 leverages established coordination with the Local Governmental Unit (LGU)/DCS in each county, county mental health systems, law enforcement, EMS, hospitals, behavioral health providers, SPOA, Assisted Outpatient Treatment (AOT), and other community services. FLACRA and Lakeview Health Services serve individuals subject to AOT and involuntary civil commitment and coordinate with LGU/DCS offices and other county partners to support treatment, care management, peer services, housing needs, and adherence to court-ordered treatment plans.

This coordination is particularly important for NY-513's homeless population. As of August 31, 2026, Coordinated Entry included 299 individuals with identified mental health needs. CoC and behavioral health partners use clinical and crisis-system coordination to connect individuals to appropriate assessment and treatment while recognizing that homelessness or mental illness alone does not establish the legal standard for involuntary intervention.

Barriers include rural geography, transportation limitations, behavioral health and psychiatric capacity, and continuity of care following hospitalization or crisis intervention. NY-513 mitigates these barriers through LGU/DCS coordination, cross-system referrals, case management, peer support, AOT/SPOA coordination, and discharge planning that connects individuals to treatment, housing, benefits, and community supports.

NY-513 will continue leveraging Article 9 and existing county crisis systems while strengthening coordination among LGU/DCS offices, law enforcement, hospitals, behavioral health, housing, and social-service providers so emergency interventions are followed by appropriate treatment and housing supports.

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)

New York has not been determined by the U.S. Department of Justice to have substantially implemented the federal Sex Offender Registration and Notification Act (SORNA). New York instead operates under the Sex Offender Registration Act (SORA), Correction Law Article 6-C, which establishes registration, address verification, and notification requirements and is administered by the NYS Division of Criminal Justice Services (DCJS).

SORA provides an established information-sharing structure across all four NY-513 counties. DCJS maintains registrant information, including home address or expected place of domicile. Registered individuals must report address changes as required by law, and DCJS notifies local law enforcement when an address changes. Information concerning Level 2 and Level 3 registrants is available through the public DCJS Sex Offender Registry, while information concerning Level 1 registrants is subject to more limited disclosure.

NY-513 does not administer the registry, determine registration requirements, or independently disclose protected registry information. Likewise, HMIS is not a sex-offender registry, and CoC providers must comply with applicable confidentiality requirements. These limitations can restrict the CoC's ability to independently share comprehensive location information beyond what is authorized under SORA.

NY-513 will leverage the existing DCJS registry and relationships with law enforcement, probation/parole, County Departments of Social Services, housing providers, and other partners to support lawful information-sharing and housing planning. When a person subject to registration requirements experiences homelessness or changes residence, providers can coordinate with appropriate justice-system partners, within applicable confidentiality requirements, to assist the individual in understanding registration obligations and identifying legally permissible housing.

Quantitatively, this statewide SORA framework applies throughout all four NY-513 counties. NY-513 does not maintain a separate CoC-wide count of individuals experiencing homelessness who are subject to SORA because HMIS is not designed to function as a sex-offender registry. Qualitatively, coordination with law enforcement and justice-system partners provides a mechanism for addressing registration and housing requirements while maintaining required confidentiality.

1C-11. Outreach Strategy.

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

(limit 2,500 characters)

The CoC does not have a HUD CoC-funded project dedicated solely to Street Outreach; however, it uses multiple outreach strategies to identify and engage people experiencing homelessness throughout its four-county rural geographic area.

FLACRA operates the SAMHSA-funded Grants for the Benefit of Homeless Individuals (GBHI) program across Ontario, Seneca, Wayne, and Yates Counties. GBHI provides outreach and engagement to individuals experiencing homelessness, including those who are unsheltered or otherwise not engaged in services, and connects individuals to behavioral health treatment, benefits, housing resources, care coordination, and recovery supports.

FLACRA also operates a 24-hour mobile Outreach and Engagement team. Peer advocates meet individuals where they are, including hotels and motels used by DSS for emergency placements and other community locations. The mobile unit is equipped with technology that allows individuals to connect remotely with clinical and medical staff when behavioral health needs are identified. Housing Peer Advocates also conduct weekly outreach at DSS offices in each of the four counties.

Because NY-513 is a large, rural geographic area, unsheltered homelessness is often less visible than in urban communities. Individuals may be living in vehicles, wooded areas, abandoned structures, or other locations not typically associated with homelessness. The CoC therefore relies on a coordinated network of CoC and non-CoC providers, DSS, behavioral health providers, food pantries, faith-based organizations, law enforcement, and other community partners to identify people experiencing homelessness and connect them to outreach, Coordinated Entry, housing, and supportive services. When individuals are identified with more immediate needs, partners can directly connect them with FLACRA's outreach teams and other appropriate resources.

For Veterans experiencing homelessness, VA Homeless Outreach staff conduct outreach at known locations and community organizations, complete assessments, and connect Veterans with VA housing, health care, and supportive services.

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

		Written Agreement
1.	Child Care (including Child Care and Development Fund)	Yes
2.	Early Childhood Providers	Yes
3.	Early Head Start	Yes
4.	Home Visiting Program (including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	Yes
5.	Head Start	Yes
6.	Healthy Start	No

7.	Public Pre-K	Yes
8.	Tribal Home Visiting Program	No
	Other (limit 150 characters)	
9.		

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

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

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

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

(limit 2,500 characters)

NY-513's CoC Written Standards require each CoC-funded project serving unaccompanied youth and/or families with children to designate a staff position responsible for informing participants of their eligibility for educational services and assisting them in accessing those services. At program enrollment and throughout case management, designated staff discuss educational needs and rights with the youth or family and coordinate with school district homeless liaisons and other education providers as needed.

Staff assist families with maintaining educational continuity, including coordination of transportation and continued participation in school services and activities. Families are also connected with resources for school supplies and other needs that could otherwise interfere with attendance. Families with preschool-age children are informed about Head Start, Pre-K, childcare, and other early childhood resources and assisted with referrals when appropriate.

Educational needs are incorporated into housing and service planning. When working with families and unaccompanied youth on housing search, staff discuss whether remaining in the current school district is preferred and, when possible, consider school location in housing identification to minimize educational disruption.

These procedures are supported by established relationships with education and early childhood providers throughout the CoC. NY-513's lead agency, FLACRA, maintains formal referral and service-linkage agreements with Geneva City School District, Penn Yan Central School District, Dundee Central School District, and Geneva Head Start. These agreements support timely referrals, communication, and coordination when families require educational or supportive services.

NY-513 also encourages school districts and education partners to participate in CoC membership and County Housing Consortium meetings, providing an ongoing connection between the homeless response and education systems.

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)

NY-513 coordinates with county Departments of Social Services (DSS) across Ontario, Seneca, Wayne, and Yates Counties to assist individuals and families involved with public systems of care and to identify housing needs that could result in homelessness. County DSS partners provide an important connection between child welfare, housing, benefits, and supportive services.

A key component of this coordination is a state-funded FLACRA Coordinated Entry Peer Advocate who is present in DSS offices weekly. The Peer Advocate meets directly with individuals and families experiencing homelessness, assists with connection to Coordinated Entry, and links households to housing and supportive services based on their needs. This provides DSS staff with a direct connection to the CoC's homeless response system.

This same process is available when a youth transitioning from foster care or the child welfare system is identified as experiencing or at risk of homelessness. DSS and child welfare staff can connect the youth directly with the Coordinated Entry Peer Advocate for assessment and linkage to appropriate housing resources and community-based services. Depending on the youth's needs, connections may include housing, benefits, behavioral health services, healthcare, education, employment and vocational services, and other supports intended to promote a stable transition from the public system of care.

Coordination is further supported through County Housing Consortia and established relationships between the CoC's lead agency, FLACRA, and county DSS/human services agencies. FLACRA maintains formal service and referral agreements with multiple county DSS/human services partners that support reciprocal referrals, communication, and coordination of services.

Together, the weekly presence of the Coordinated Entry Peer Advocate within DSS offices, direct referral pathways, and ongoing county-level coordination provide a mechanism for identifying youth with housing needs and connecting them to services before or during their transition from foster care or other child welfare systems.

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)

NY-513 does not have a U.S. Department of Health and Human Services (HHS) Runaway and Homeless Youth (RHY)-funded Street Outreach Program, Basic Center Program, Transitional Living Program, or Maternity Group Home within the CoC's four-county geographic area.

In the absence of an HHS RHY-funded provider, NY-513 coordinates with county Departments of Social Services, school districts, housing and homeless service providers, behavioral health providers, and other youth-serving community organizations to identify youth experiencing or at risk of homelessness and connect them to appropriate resources. Youth experiencing homelessness may access the CoC's Coordinated Entry system for assessment and connection to available housing and supportive services.

Youth remain an important population for NY-513. An analysis of 2025 HUD Point-in-Time Count data by the New York State Comptroller found that individuals under age 18 represented 21.1% of the homeless population counted in the Wayne, Ontario, Seneca, and Yates Counties CoC. NY-513 also engages youth-serving providers in PIT planning, including identifying locations and times where youth experiencing homelessness are most likely to be found.

NY-513 will continue reviewing PIT, Coordinated Entry, and other available youth data to better understand the prevalence and needs of youth experiencing homelessness. Based on identified need, the CoC will explore opportunities to expand youth-specific partnerships and resources and encourage eligible organizations to pursue future youth-focused funding opportunities, including Youth Homelessness Demonstration Program (YHDP) funding.

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)

NY-513 partners with FLACRA's Women and Children's Reintegration Program, an 8-unit scattered-site program reported as Transitional Housing on the CoC's HIC. The program is a distinct NYS OASAS Part 820 Reintegration PRU serving women with children. It combines transitional housing with substance use disorder treatment, recovery supports, case management, and services supporting family stability and transition to permanent housing.

1C-13a. Collaboration Related to Families with Children—Supportive Services to Improve Income to Pay Rent.

Describe how the project(s) identified in 1C-13 provides supportive services focused on improving incomes to pay rent, such as workforce development, job training, or registered apprenticeship programs.

(limit 2,500 characters)

FLACRA's Women and Children's Part 820 Reintegration Program, an 8-unit scattered-site Transitional Housing program, provides individualized supportive services focused on increasing participants' income and ability to maintain permanent housing. Employment, education, and vocational needs are assessed as part of individualized service planning, and participants are connected to services based on their identified goals and needs.

Participants have access to FLACRA's OASAS-funded Vocational Rehabilitation program, which provides vocational and employment supports to help individuals prepare for, obtain, and maintain employment. Through this program, FLACRA partners with NADAP to provide job development services, creating a direct pathway from vocational assessment and employment preparation to job development and employment opportunities.

FLACRA also maintains formal partnerships with the Finger Lakes Workforce Investment Board and Ontario County Workforce Development, providing additional referral pathways to workforce development, employment, and training services. Participants may also be connected to education, benefits, vocational, and employment resources through community colleges, vocational rehabilitation partners, and county Departments of Social Services.

Case management staff work with participants to address barriers that may interfere with employment and income growth, including transportation, childcare, treatment and recovery needs, education, benefits, and other family needs. Employment and income goals are incorporated into ongoing service planning so participants can increase earned income and other available resources and be better prepared to afford rent and maintain permanent housing.

Families with children served through NY-513's CoC-funded housing projects can also be connected to these workforce, vocational rehabilitation, education, and employment resources based on their individualized needs.

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)

FLACRA's Women and Children's Part 820 Reintegration Program, an 8-unit scattered-site Transitional Housing program, leverages mainstream family service systems to support participating families. Staff coordinate with county Departments of Social Services to assist eligible families with accessing and maintaining Temporary Assistance, including TANF when eligible, SNAP, Medicaid, childcare assistance, and other benefits and resources available to families with children.

The program also leverages Medicaid to support eligible Part 820 Reintegration treatment and recovery services, allowing housing and supportive resources to be coordinated with behavioral health treatment, care coordination, and other services necessary to support family stability. Case managers help participants identify eligible benefits, complete applications and recertifications, address barriers to accessing services, and coordinate with community providers.

By combining the project's housing resources with Medicaid-funded treatment and recovery services and mainstream family assistance programs administered through county and state systems, the program expands the resources available to participating families and supports their transition toward permanent housing and increased self-sufficiency.

Families with children served through NY-513's CoC-funded housing projects can also be connected to these workforce, vocational rehabilitation, education, and employment resources based on their individualized needs.

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)

FLACRA's Women and Children's Part 820 Reintegration Program is an 8-unit scattered-site Transitional Housing program specifically designed to allow women with children to remain together while the parent receives treatment, recovery support, and services designed to promote successful transition to independent living.

The program combines housing with individualized case management, substance use disorder treatment and recovery services, family support, parenting and independent living skills, and connections to community resources. Parenting skills are incorporated into the range of services available through Reintegration, and participants receive individualized service planning based on the needs of the parent and family.

The program coordinates childcare and educational services for children and works with families to maintain children's participation in appropriate educational services. Participants are also connected to healthcare based on family needs, including primary and behavioral healthcare and appropriate pregnancy-related, maternal, and pediatric healthcare services. Staff assist families with coordinating appointments, benefits, transportation, and connections to community providers.

Services are individualized to address the needs of both the parent and children while supporting recovery, family stability, development of parenting and independent living skills, and successful transition from transitional housing to permanent housing.

Families with children served through NY-513's CoC-funded housing projects can also be connected to these workforce, vocational rehabilitation, education, and employment resources based on their individualized needs.

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)

NY-513 partners with the U.S. Department of Veterans Affairs (VA), including VA homeless outreach and HUD-VASH staff, to identify and connect Veterans experiencing homelessness to housing, healthcare, and supportive services. FLACRA operates a 17-unit permanent housing complex on the Canandaigua VA campus. Soldier On, an SSVF provider, is represented on the CoC Board and participates in CoC planning and funding decisions.

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)

NY-513 partners with Survivor Advocacy Center of the Finger Lakes, Safe Harbors of the Finger Lakes, and Family Counseling Services of the Finger Lakes. These victim service providers actively participate in the CoC and Housing Consortium activities and collaborate with the CoC on coordinated entry, safety planning, housing and services coordination, training, and policies to ensure survivors have access to housing and supportive services.

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)

NY-513 partners with FLACRA and county criminal justice systems to prevent homelessness among individuals transitioning from incarceration and court-ordered programs. FLACRA has re-entry staff, clinicians, and peers working within Ontario and Yates County Jails to support transition planning and connections to housing, treatment, recovery, and community services. FLACRA also participates in all Drug Treatment Courts throughout the CoC.

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)

NY-513 partners with FLACRA and Rochester's Cornerstone Group at Town Side at Pre-Emption in Geneva, which includes 44 ESSHI supportive housing units serving individuals experiencing homelessness who are high-utilizers of Medicaid healthcare services. FLACRA screens individuals for eligibility and provides supportive services, care coordination, and connections to medical and behavioral healthcare to address complex health needs.

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)

NY-513 partners with FLACRA and Rochester's Cornerstone Group at Town Side at Pre-Emption in Geneva, which includes 44 ESSHI supportive housing units serving individuals aged 55 and older experiencing homelessness who are high utilizers of Medicaid services. FLACRA screens individuals for eligibility and provides ESSHI supportive services to promote housing stability and address health, behavioral health, and aging-related needs.

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)

NY-513 has two PSH projects that prioritize individuals experiencing chronic homelessness: FLACRA's Shelter Plus Care (SPC), which is dedicated to serving individuals experiencing chronic homelessness, and FLACRA's Wayne County PSH. Wayne PSH is not CH-dedicated but prioritizes applicants through Coordinated Entry based on vulnerability and service needs, resulting in individuals with the highest needs, including many experiencing chronic homelessness, being prioritized for referral.

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)

FLACRA's Shelter Plus Care (SPC) and Wayne County PSH provide participants access to behavioral healthcare in their homes through FLACRA's COTI Outreach and Engagement team. COTI's mobile clinicians provide behavioral health outreach, assessment, engagement, and clinical services directly in participants' housing, reducing barriers related to transportation and access to traditional office-based services.

SPC and Wayne PSH case management staff coordinate with COTI when behavioral health needs are identified and assist participants in accessing appropriate services. The mobile model allows clinicians to engage participants in their housing environment and provide services based on individual needs.

Participants in both projects also have access to FLACRA's broader continuum of behavioral health and substance use disorder treatment, including outpatient clinics and CCBHC services. Staff facilitate connections to psychiatric and medication services, substance use disorder treatment, recovery and peer supports, care management, and other community-based services as needed.

This combination of mobile, in-home clinical services and access to FLACRA's treatment continuum allows SPC and Wayne PSH participants to receive behavioral healthcare where they live while maintaining access to additional levels of treatment and support based on individual need.

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)

FLACRA's Shelter Plus Care (SPC) and Wayne County PSH assess participants on an ongoing basis to determine whether behavioral health, substance use disorder, medical, functional, or other needs indicate a need for a higher level of care. As part of ongoing service planning, case managers monitor changes in participant needs and coordinate clinical assessment with appropriate behavioral health and healthcare providers when concerns are identified.

When assessment indicates that a participant's needs exceed the supports that can appropriately be provided in PSH and through community-based services, staff coordinate access to the appropriate level of care. Depending on individual need, this may include intensive behavioral health services, crisis evaluation, residential substance use disorder treatment, inpatient treatment, assisted living, skilled nursing, or another appropriate residential or healthcare setting.

FLACRA's treatment continuum and community partnerships, including its relationship with Clifton Springs CPEP for psychiatric emergency evaluation, provide resources for assessment, referral, and transition when a higher level of care is indicated.

SPC and Wayne PSH staff work collaboratively with participants and involved providers to coordinate referrals, transitions, and continuity of care while ensuring decisions are based on individualized assessment and participant needs.

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)

FLACRA's Shelter Plus Care (SPC) and Wayne County PSH assess participant readiness to transition to unsubsidized or other permanent housing through ongoing individualized service planning and case management. Readiness is based on each participant's circumstances, goals, housing stability, and continued need for PSH assistance rather than length of time in the program.

Case managers regularly review housing stability, ability to meet tenancy obligations, income and benefits, budgeting and financial management, independent living skills, behavioral and physical health needs, connection to community-based services, and the level of ongoing support needed to maintain housing.

When a participant demonstrates increased stability and may no longer require PSH assistance, staff work collaboratively with the participant to assess readiness and identify appropriate permanent housing options. Moving on is voluntary and individualized and may include unsubsidized rental housing or other permanent housing resources for which the participant is eligible.

When moving on is appropriate, staff assist with housing search and navigation, applications, landlord coordination, budgeting, benefits and income planning, and connections to community-based services. Transition planning supports continuity of services and long-term housing stability following exit from PSH.

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.	08/07/2026
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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)

Wayne County Action Program, Inc. made the mutual decision with the CoC to reallocate its Success Center TH-RRH project. The project was reviewed with the HUD Buffalo Field Office regarding CoC eligibility requirements and its budget structure. Changes were made, and the CoC and Wayne County Action Program, Inc. were in discussions regarding use of the Transition Grant option to move the project to a Transitional Housing model; however, it was determined that because Wayne County Action Program, Inc. owned the building in which the transitional housing units were located, the proposed project structure was ineligible.

Based on this determination, the CoC and Wayne County Action Program, Inc. mutually agreed to reallocate the project. Wayne County Action Program, Inc. was notified of the CoC's final project ranking and reallocation decision on August 7, 2026.

When HUD reopened the FY2026 CoC Competition, HUD subsequently issued a waiver of 24 CFR 578.51(b) permitting private nonprofit applicants, recipients, and subrecipients to administer rental assistance. This waiver potentially addressed the eligibility issue affecting the Success Center project; however, it was issued after NY-513 had completed its local review, ranking, and project notification process.

NY-513 remains a strong partner with Wayne County Action Program, Inc. and will continue to explore future project opportunities for CoC funding in FY2027 and beyond.

All other projects performed well and were ranked accordingly. NY-513 used the reallocated funds from the Success Center project, along with available bonus funding, to create a new Transitional Housing project consistent with HUD's FY2026 funding priorities.

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?	No
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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 ServicePoint
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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)

Between the 2025 and 2026 PIT Counts, NY-513 continued to strengthen implementation of the unsheltered count by expanding its volunteer base across Ontario, Seneca, Wayne, and Yates Counties. The increased number of volunteers allowed county teams to cover a broader geographic area and increased community awareness and participation in the PIT Count.

NY-513 maintained established county PIT leads, including Finger Lakes Community Action Program in Wayne County, Keuka Housing Council in Yates County, Eaglestar Housing in Ontario County, and FLACRA in Seneca County. County leads coordinated returning and new volunteers, provided training to additional volunteers, and built upon the experience of volunteers who participated in previous counts.

County leads also strengthened coordination with local law enforcement to identify known locations where individuals experiencing homelessness had been observed and continued coordination with county Departments of Social Services and other community partners to help identify areas for outreach during the count.

NY-513 identified five individuals experiencing unsheltered homelessness in both the 2025 and 2026 PIT Counts. Although the overall number remained unchanged, the expanded volunteer base increased the CoC's capacity to cover its large, predominantly rural geographic area and strengthened confidence that the count reached known locations where individuals experiencing unsheltered homelessness may be staying.

Increased coordination with law enforcement, county Departments of Social Services, and other community partners helped county teams identify locations for targeted outreach. The combination of experienced returning volunteers and newly trained volunteers also strengthened local knowledge and consistency in count implementation. The unchanged count, despite expanded geographic coverage and outreach capacity, provides the CoC with greater confidence that the PIT results reflect the relatively small and geographically dispersed unsheltered population within NY-513.

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)

NY-513 selected January 1, 2025 through December 31, 2025 as its evaluation period. NY-513 is a predominantly rural Continuum of Care encompassing Ontario, Seneca, Wayne, and Yates Counties. The CoC does not typically experience established encampments. Individuals experiencing unsheltered homelessness are generally dispersed throughout the four-county area and may stay in wooded areas, under bridges, in vehicles, abandoned structures, or other places not meant for human habitation.

During the January 29, 2025 Point-in-Time Count, NY-513 identified five individuals experiencing unsheltered homelessness across the four-county region. Because rural unsheltered homelessness can be dispersed and less visible, the CoC supplements PIT information with community-based outreach, Coordinated Entry, HMIS data, and information from community partners.

During the evaluation period, FLACRA's COTI Outreach and Engagement team and SAMHSA-funded Grants for the Benefit of Homeless Individuals (GBHI) team provided outreach and engagement throughout the CoC. GBHI operated as a Street Outreach project and served 206 individuals during the 2025 reporting period, including 99 identified as chronically homeless. This total includes participants who entered prior to 2025 and remained active during the reporting period.

GBHI participants represented a range of living situations. Among adults with living-situation information recorded at project start, seven had entered from a place not meant for habitation, while others entered from emergency shelter or Safe Haven, treatment facilities, transitional or residential programs, temporary arrangements with family or friends, and other housing situations. Therefore, the total served by GBHI does not represent the number of individuals who were unsheltered or residing in encampments.

Outreach focused on engaging individuals experiencing homelessness, identifying needs and barriers, and connecting them to housing, shelter, treatment and recovery services, healthcare, benefits, and other resources. FLACRA also coordinated with county DSS, law enforcement and first responders, healthcare and behavioral health providers, housing providers, Veteran Services, and other community partners.

During 2025, 131 GBHI participants exited the program, with 105 (81%) exiting to positive housing destinations, including 57 to permanent housing. No GBHI participants were recorded as exiting to a place not meant for habitation.

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

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

** nbsp;****2A-4c. Reduce Encampments—Plans to Reduce Encampments.**

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

(limit 2,500 characters)

NY-513 does not currently have established encampments. As a predominantly rural CoC encompassing Ontario, Seneca, Wayne, and Yates Counties, individuals experiencing unsheltered homelessness are generally dispersed throughout the four-county geographic area rather than concentrated in encampments. Individuals may be identified in wooded areas, under bridges, in vehicles, abandoned structures, or other places not meant for human habitation.

NY-513 will continue its coordinated approach to identifying and engaging individuals experiencing unsheltered homelessness and preventing the development of encampments. FLACRA's COTI Outreach and Engagement team and SAMHSA-funded GBHI team provide community-based outreach throughout the CoC and engage individuals who may not otherwise access traditional service settings.

Through COTI, GBHI, Coordinated Entry, and partnerships with county Departments of Social Services, law enforcement and first responders, healthcare and behavioral health providers, housing providers, Veteran Services, and other community-based organizations, individuals are connected to housing and shelter resources, treatment and recovery services, healthcare, benefits, care coordination, and other supports based on individual needs.

The CoC will maintain communication with community partners to identify emerging areas of unsheltered homelessness and mobilize outreach resources promptly. If an encampment develops, COTI, GBHI, and other appropriate community resources will be engaged to connect individuals to available housing, shelter, treatment, and supportive services. NY-513 will continue using Coordinated Entry, HMIS, PIT information, outreach data, and information from community partners to monitor unsheltered homelessness throughout the four-county region.

2A-5. Reducing the Number of First Time Homeless—CoC's Plan.

Describe your CoC's plan to decrease the number of individuals and families becoming homeless for the first time.

(limit 2,500 characters)

NY-513's plan to reduce first-time homelessness focuses on early identification of housing instability, homelessness prevention, diversion, and coordinated access to community resources across Ontario, Seneca, Wayne, and Yates Counties. The CoC reviews HMIS and System Performance Measure data to identify trends and factors contributing to first-time homelessness and uses this information to inform local planning and prevention strategies.

County Departments of Social Services (DSS) are key partners in prevention and diversion efforts and frequently serve as an initial point of contact for households experiencing a housing crisis. DSS and community partners work to identify alternatives to emergency shelter whenever safe and appropriate and connect households to resources that may prevent homelessness, including rent and utility arrears, security deposits, public benefits, rental assistance, and other available financial supports based on eligibility.

The CoC also leverages the New York State Medicaid Social Care Network (SCN) as an emerging homelessness-prevention resource. Agency providers throughout NY-513 participate in the regional SCN and can screen, navigate, refer, and/or provide eligible Medicaid members with housing-related services. Depending on eligibility, these resources may include rental or temporary housing assistance, back rent, security deposits, utility assistance, pre-tenancy services, housing navigation, eviction prevention, and tenancy-sustaining supports. This provides an additional pathway for addressing housing instability before a household enters the homeless response system.

Diversion is used to help households resolve immediate housing crises without entering homelessness. DSS staff, Peer Advocates, 211, housing and service providers, and other community partners assist households with identifying safe alternatives, including landlord engagement and negotiation, connection to financial and food resources, and support for households temporarily residing with family or friends while permanent housing is secured.

County Housing Consortia provide forums for identifying emerging needs, available prevention resources, and service gaps. NY-513 will continue monitoring first-time homelessness through HMIS and System Performance Measures and use results to evaluate prevention and diversion strategies, target resources, strengthen partnerships, and adjust system planning.

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)

NY-513 regularly reviews HMIS and System Performance Measure data to monitor length of time homeless and identify barriers delaying permanent housing. FY2025 results demonstrate an increased length of time homeless and reinforce the need for targeted strategies to move individuals and families into stable housing more quickly.

A significant barrier within NY-513 is the limited availability of affordable rental housing. The CoC's rural Finger Lakes communities face constrained rental supply, rising housing costs, and competition for available units, including pressure from short-term and seasonal rentals. Local housing needs assessments have documented housing affordability, rental availability, housing supply, and short-term rentals as important local housing issues. These conditions can extend homelessness even when households are actively engaged in housing search and prepared to move into permanent housing.

NY-513 addresses these barriers through early housing planning, Coordinated Entry, housing navigation, landlord engagement, and assistance resolving barriers that delay placement. Providers help households locate units, complete applications, obtain documentation, communicate with landlords, access benefits, and address security deposits, move-in costs, transportation, and other barriers when resources are available. Coordinated Entry considers length and frequency of homelessness when connecting households to appropriate housing and service resources.

Agency providers participating in the regional Social Care Network can connect eligible Medicaid members to housing-related supports that may help remove financial and service barriers to housing. FLACRA's COTI Outreach and Engagement team and SAMHSA-funded GBHI program provide outreach throughout the four counties and connect individuals to housing, treatment, benefits, care coordination, and other resources. County DSS and community partners also provide housing assistance and case management to households in emergency housing.

NY-513 will continue supporting development of affordable, transitional, supportive, and permanent housing and use HMIS and SPM data to identify barriers, target resources, strengthen housing navigation and landlord engagement, and evaluate progress in reducing length of time homeless.

	2A-7. Successful Permanent Housing Placement—Exits to Unsubsidized Housing.	
	Based on HMIS data, what percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing?	22.70%

Describe how you calculated the data for this response.

(limit 2,500 characters)

NY-513 reviewed HMIS data for the 12-month period of January 1, 2025, through December 31, 2025. The universe included all HMIS-participating Transitional Housing (TH), Rapid Re-Housing (RRH), and Permanent Supportive Housing (PSH) projects within the CoC. During the reporting period, 119 program participants exited from TH, RRH, or PSH projects.

To determine the percentage exiting to unsubsidized permanent housing, NY-513 used the four applicable HMIS Data Element 3.12 Exit Destination categories identified by HUD. Of the 119 participants who exited, 4 exited to staying or living with family, permanent tenure; 4 exited to staying or living with friends, permanent tenure; 19 exited to rental by client, no ongoing housing subsidy; and 0 exited to owned by client, no ongoing housing subsidy. These categories totaled 27 exits to unsubsidized permanent housing.

NY-513 calculated the percentage by dividing the 27 qualifying exits by the 119 total participants who exited TH, RRH, and PSH during the reporting period, resulting in 22.7% of participants exiting to unsubsidized housing.

The CoC will continue monitoring HMIS exit data and working with providers to support successful transitions to permanent housing through housing navigation, landlord engagement, employment and income supports, connection to mainstream benefits, and individualized services that strengthen participants' ability to obtain and maintain permanent housing without ongoing rental assistance when appropriate.

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.	01/29/2026
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2A-8a.	HIC and PIT Count Data—HDX 2.0 Submission Date.	
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	Did your CoC submit its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count data in HDX 2.0 by April 30, 2026, 8:00 p.m. EDT?	Yes
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2A-8b.	Longitudinal System Analysis (LSA) Data—HDX 2.0 Submission Date.	
	You must upload your CoC's FY 2026 HDX Competition Report to the 4A. Attachments Screen.	

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

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	326	14	340	100.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	131	0	124	94.66%
4. Rapid Re-Housing (RRH) beds	22	0	22	100.00%
5. Permanent Supportive Housing (PSH) beds	182	0	182	100.00%
6. Other Permanent Housing (OPH) beds	28	0	28	100.00%

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)

Not Applicable – all applicable project types have an HMIS/comparable database bed coverage rate of at least 85%.

3A. Policy Initiatives

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

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

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

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

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

4A. Attachments Screen For All Application Questions

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

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

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

1.	You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.		
2.	You must upload an attachment for each document listed where 'Required?' is 'Yes'.		
3.	We prefer that you use PDF files, though other file types are supported—please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.		
4.	Attachments must match the questions they are associated with.		
5.	Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process.		
6.	If you cannot read the attachment, it is likely we cannot read it either.		
	. We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).		
	. We must be able to read everything you want us to consider in any attachment.		
7.	After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.		
8.	Only use the 'Other' attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.		
Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	List of TH/RRH/PS...	09/27/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	List of CoC Progr...	09/27/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	Supportive Servic...	09/27/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	Evidence of Coord...	09/27/2026
05. 1D-1. Local Competition Scoring Tool	Yes	Local Competition...	09/27/2026

06. 1D-2c. Local Competition Selection Results	Yes	Local Competition...	09/27/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	FY 2026 HDX Compe...	09/27/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No		
09. 3A-2a. Project List for Other Federal Statutes	No		
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No	CoC's Policy or S...	09/27/2026
11. Other	No		

Attachment Details

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

Attachment Details

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

Attachment Details

Document Description: Supportive Services Participation Agreement

Attachment Details

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

Attachment Details

Document Description: Local Competition Scoring Tool

Attachment Details

Document Description: Local Competition Selection Results

Attachment Details

Document Description: FY 2026 HDX Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

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

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/27/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/27/2026
1C. Coordination and Engagement	09/27/2026
1D. Project Review/Ranking	09/27/2026
2A. HMIS Implementation	09/27/2026
3A. Policy Initiatives	09/27/2026
4A. Attachments Screen	09/27/2026
Submission Summary	No Input Required

NY-513 Continuum of Care 1C-1

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

Project Name	Type	Project Provider	On-Site SUD Treatment	Treatment Provider / Delivery
Wayne County Permanent Supportive Housing	PSH	Finger Lakes Area Counseling and Recovery Agency (FLACRA)	Yes	FLACRA COTI Outreach and Engagement Team – mobile clinical staff can provide on-site clinical substance use disorder services in participants' scattered-site housing and community settings. The project also has access to FLACRA outpatient and community-based treatment services.
Transitional Housing – New Project	TH	Finger Lakes Area Counseling and Recovery Agency (FLACRA)	Yes	FLACRA COTI Outreach and Engagement Team – mobile clinical staff can provide on-site clinical substance use disorder services in participants' scattered-site housing and community settings. The project also has access to FLACRA outpatient and community-based treatment services.
Shelter Plus Care for the Chronically Homeless	PSH	Finger Lakes Area Counseling and Recovery Agency (FLACRA)	Yes	FLACRA COTI Outreach and Engagement Team – mobile clinical staff can provide on-site clinical substance use disorder services in participants' scattered-site housing and community settings. The project also has access to FLACRA outpatient and community-based treatment services.

NY-513 Continuum of Care 1C-1F

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

NY-513 CoC Program projects do not designate specific housing units as requiring substance use disorder treatment for every participant. Participants are required to engage in supportive services and activities identified through their Individualized Service Plans. When substance use disorder treatment is identified as clinically appropriate through assessment, clinical recommendation, or the Individualized Service Plan, the participant is expected to engage in those services. Therefore, no units are categorically designated as requiring substance use disorder treatment for all occupants. Participants without an identified need for SUD treatment engage in other appropriate supportive services and self-sufficiency activities based on their individualized needs.

CoC Program Project	Project Type	Project Provider	Total Units	Units Requiring SUD Treatment
Wayne County Permanent Supportive Housing	PSH	Finger Lakes Area Counseling and Recovery Agency (FLACRA)	12	0
Transitional Housing - New Project	TH	Finger Lakes Area Counseling and Recovery Agency (FLACRA)	10	0
Shelter Plus Care for the Chronically Homeless	PSH	Finger Lakes Area Counseling and Recovery Agency (FLACRA)	15	0



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28 East Main Street
Clifton Springs, NY 14432
(315) 462-9466
Fax (315) 462-6400

SUPPORTIVE SERVICES PARTICIPATION AGREEMENT

Participant Name:	
Program/Project Name:	
Effective Date:	
Case Manager:	

1. Purpose

This Agreement outlines supportive service expectations and participation requirements for individuals participating in HUD Continuum of Care (CoC) funded program. The Program supports housing stability, treatment and recovery when applicable, employment or income growth, self-sufficiency, and progress toward independent living.

2. Supportive Service Participation Requirement

Participants are expected to actively participate in supportive services and structured activities identified in their Individualized Service Plan. Activities may include case management, employment training, education, treatment services, recovery supports, life skills, budgeting, benefits assistance, volunteer/community service, or other approved activities.

Participants will be required to complete up to forty (40) hours per week of combined supportive service and self-sufficiency activities. The required level of participation will be individualized based on program type, participant needs, employment status, clinical recommendations, disability-related accommodations, age, family responsibilities, and other relevant factors.

3. Treatment, Recovery, and Wellness Expectations

When treatment, recovery, mental health, substance use disorder services, or other wellness supports are identified as appropriate through assessment, clinical recommendation, or the Individualized Service Plan, the participant is expected to engage in those services. This may include referral, intake, attendance, care coordination, medication support, recovery meetings, counseling, or other clinically appropriate services.

4. Individualized Service Plan

The participant and Program staff will develop and review an Individualized Service Plan that identifies goals, required activities, referrals, timelines, and progress toward housing stability and self-sufficiency. The plan will address:

- housing stability and lease compliance
- employment, education, vocational training, or income growth
- treatment, recovery, behavioral health, or wellness needs
- life skills, budgeting, and independent living skills
- benefits, health care, transportation, childcare, and other supports

5. Participant Responsibilities

- Maintain regular communication with Program staff.
- Attend scheduled meetings, appointments, and required activities.
- Participate in case management and service planning.



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- Provide accurate and updated information regarding income, employment, household composition, contact information, and program eligibility.
- Comply with lease obligations, occupancy expectations, and program rules, if applicable.
- Treat staff, residents, neighbors, landlords, and community partners respectfully.
- Avoid threatening, violent, illegal, or unsafe behavior that places others or the housing placement at risk.

6. Documentation of Participation

Participants will be required to provide documentation of participation, such as appointment verification, attendance logs, employment or training schedules, treatment verification, pay stubs, benefit documentation, or other records needed to verify progress and compliance with the Individualized Service Plan.

7. Progressive Intervention and Program Compliance

If a participant does not reasonably engage in required supportive services or structured activities, Program staff will make reasonable efforts to re-engage the participant. Interventions will include outreach, case conference, revised service planning, increased staff contact, written notice, corrective action plan, or review of continued program participation.

Continued failure to participate, repeated missed appointments, refusal to engage in service planning, serious lease violations, fraud, violent or threatening behavior, or other significant noncompliance may result in termination from the Program consistent with HUD requirements, due process protections, reasonable accommodation obligations, and applicable agency procedures.

8. Reasonable Accommodation and Individual Considerations

The Program will consider reasonable accommodations and individual circumstances, including disability, age, medical condition, family responsibilities, safety concerns, and clinical recommendations. Participants may request an accommodation or modification to participation expectations at any time.

9. Confidentiality, HMIS, Nondiscrimination, VAWA, and Grievances

Participant information will be maintained in accordance with HUD confidentiality requirements, HMIS standards, applicable privacy laws, and agency policies. The Program does not discriminate based on protected characteristics. Survivors of domestic violence, dating violence, sexual assault, stalking, or human trafficking will receive VAWA protections. Participants may file a grievance or request review of program decisions without retaliation.

10. Acknowledgment

By signing below, I acknowledge that I have reviewed this Agreement, had the opportunity to ask questions, and understand that active participation in supportive services and activities identified in my Individualized Service Plan may be required as a condition of continued program participation.

Participant Signature:	Date:
Printed Name:	
Program Representative Signature:	Date:
Printed Name/Title:	

NY-513 Continuum of Care 1C-10

Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety

The attached executed Services and Linkage Agreements/Memoranda of Understanding document FLACRA's coordination with local justice-system and public-health partners. The agreements demonstrate formal referral relationships, coordinated service delivery, communication when agencies are serving the same individuals, and linkages to appropriate treatment and community-based services.

Included documentation:

1. **Yates County Jail** - Justice/public-safety coordination, referrals, reentry/incarceration services, and treatment linkages.
2. **Wayne County Probation Department** - Justice-system coordination, reciprocal referrals, communication, and service linkage.
3. **Seneca County Public Health** - County public-health coordination, referrals, continuity of care, and avoidance of duplication.
4. **Yates County Public Health** - County public-health coordination, referrals, continuity of care, and service linkage.



Services and Linkage Agreement Memorandum of Understanding

This Memorandum of Understanding between **Yates County Jail** and *Finger Lakes Area Counseling and Recovery Agency, Inc. (FLACRA)*, 28 East Main Street, Clifton Springs, NY 14432 serves to enhance the commitment and collaboration between both organizations with the goal of assuring continuity and appropriateness of care for mutually served clients.

The intent of this agreement is to ensure that individuals and their families affected by Substance Use and Related Disorders receive comprehensive and coordinated services and linkage.

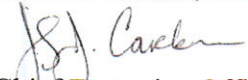
Principles:

1. Both parties agree to protect the confidentiality of the clients in accordance with Title 42 Part 2 of the Code of Federal Regulations, governing the Confidentiality of Substance Use Disorder Patient Records, as well as provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Both parties agree to make and receive appropriate and timely referrals, coordinate quality care and avoid duplication of services.
3. In the event both agencies are providing services concurrently, the agencies will provide appropriate communication of client progress, changes to client status or other critical information that is essential to service provision and quality of care, so long as all appropriate consents and/or authorizations have been received.
4. FLACRA agrees to refer clients for additional treatment outside the agency when the agency services preclude timely access to treatment; and/or when the client requests such services.
5. As a Center of Treatment Innovation (COTI), FLACRA agrees to provide evaluation and/or potential treatment services through the Outpatient Clinics, 820 Residential Treatment programming, Reentry/Incarceration Services, Addictions Crisis Services, Detox, Care Management, Housing and Community-Based Services, and/or the Mobile Response Unit. FLACRA also provides medication-assisted treatment, including methadone, through its licensed Opioid Treatment Program (OTP), the Certified Community Behavioral Health Clinics (CCBHC), and Community Recovery Centers.
6. **Yates County Jail** include FLACRA in their referral source list for clients as an agency for additional and necessary services. **Yates County Jail** will also provide services for clients referred by FLACRA when there is need of an additional service or level of treatment.

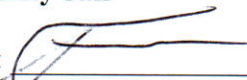
This agreement will be in effect from the date of execution and shall remain in effect for 1 year thereafter. Either party may terminate this agreement upon 15 days written notice to the other party via Registered Mail.

This agreement shall terminate immediately if either party fails to maintain existing licenses, certification, or accreditation in good standing. The parties agree to provide written notification of additions or deletions of services.

Jennifer Carlson, MPA


Chief Executive Officer
FLACRA 06/17/26

Yates County Jail

Signature: 
Printed Name: Francis E. Ryan, Sheriff
Date: 07/14/2026



Services and Linkage Agreement Memorandum of Understanding

This Memorandum of Understanding between **Wayne County Probation Department** and *Finger Lakes Area Counseling and Recovery Agency, Inc. (FLACRA)*, 28 East Main Street, Clifton Springs, NY 14432 serves to enhance the commitment and collaboration between both organizations with the goal of assuring continuity and appropriateness of care for mutually served clients.

The intent of this agreement is to ensure that individuals and their families affected by Substance Use and Related Disorders receive comprehensive and coordinated services and linkage.

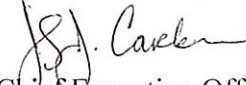
Principles:

1. Both parties agree to protect the confidentiality of the clients in accordance with Title 42 Part 2 of the Code of Federal Regulations, governing the Confidentiality of Substance Use Disorder Patient Records, as well as provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Both parties agree to make and receive appropriate and timely referrals, coordinate quality care and avoid duplication of services.
3. In the event both agencies are providing services concurrently, the agencies will provide appropriate communication of client progress, changes to client status or other critical information that is essential to service provision and quality of care, so long as all appropriate consents and/or authorizations have been received.
4. FLACRA agrees to refer clients for additional treatment outside the agency when the agency services preclude timely access to treatment; and/or when the client requests such services.
5. As a Center of Treatment Innovation (COTI), FLACRA agrees to provide evaluation and/or potential treatment services through the Outpatient Clinics, 820 Residential Treatment programming, Reentry/Incarceration Services, Addictions Crisis Services, Detox, Care Management, Housing and Community-Based Services, and/or the Mobile Response Unit. FLACRA also provides medication-assisted treatment, including methadone, through its licensed Opioid Treatment Program (OTP), the Certified Community Behavioral Health Clinics (CCBHC), and Community Recovery Centers.
6. **Wayne County Probation Department** include FLACRA in their referral source list for clients as an agency for additional and necessary services. **Wayne County Probation Department** will also provide services for clients referred by FLACRA when there is need of an additional service or level of treatment.

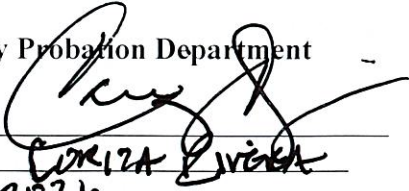
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This agreement shall terminate immediately if either party fails to maintain existing licenses, certification, or accreditation in good standing. The parties agree to provide written notification of additions or deletions of services.

Jennifer Carlson, MPA


Chief Executive Officer
FLACRA
Date: 1/23/26

Wayne County Probation Department

Signature: 
Printed Name: Corina E. Smith
Date: 1/27/2026



Services and Linkage Agreement Memorandum of Understanding

This Memorandum of Understanding between **Seneca County Public Health** and *Finger Lakes Area Counseling and Recovery Agency, Inc. (FLACRA)*, 28 East Main Street, Clifton Springs, NY 14432 serves to enhance the commitment and collaboration between both organizations with the goal of assuring continuity and appropriateness of care for mutually served clients.

The intent of this agreement is to ensure that individuals and their families affected by Substance Use and Related Disorders receive comprehensive and coordinated services and linkage.

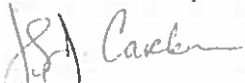
Principles:

1. Both parties agree to protect the confidentiality of the clients in accordance with Title 42 Part 2 of the Code of Federal Regulations, governing the Confidentiality of Substance Use Disorder Patient Records, as well as provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Both parties agree to make and receive appropriate and timely referrals, coordinate quality care and avoid duplication of services.
3. In the event both agencies are providing services concurrently, the agencies will provide appropriate communication of client progress, changes to client status or other critical information that is essential to service provision and quality of care, so long as all appropriate consents and/or authorizations have been received.
4. FLACRA agrees to refer clients for additional treatment outside the agency when the agency services preclude timely access to treatment; and/or when the client requests such services.
5. As a Center of Treatment Innovation (COTI), FLACRA agrees to provide evaluation and/or potential treatment services through the Outpatient Clinics, 820 Residential Treatment programming, Reentry/Incarceration Services, Addictions Crisis Services, Detox, Care Management, Housing and Community-Based Services, and/or the Mobile Response Unit. FLACRA also provides medication-assisted treatment, including methadone, through its licensed Opioid Treatment Program (OTP), the Certified Community Behavioral Health Clinics (CCBHC), and Community Recovery Centers.
6. **Seneca County Public Health** include FLACRA in their referral source list for clients as an agency for additional and necessary services. **Seneca County Public Health** will also provide services for clients referred by FLACRA when there is need of an additional service or level of treatment.

This agreement will be in effect from the date of execution and shall remain in effect for 1 year thereafter. Either party may terminate this agreement upon 30 days written notice to the other party via Registered Mail.

This agreement shall terminate immediately if either party fails to maintain existing licenses, certification, or accreditation in good standing. The parties agree to provide written notification of additions or deletions of services.

Jennifer Carlson, MPA


Chief Executive Officer
FLACRA
Date: 10/25/2025

Seneca County Public Health

Signature: 
Printed Name: Scott D. King, MPH
Date: 10-28-25



Services and Linkage Agreement Memorandum of Understanding

This Memorandum of Understanding between **Yates County Public Health** and *Finger Lakes Area Counseling and Recovery Agency, Inc. (FLACRA)*, 28 East Main Street, Clifton Springs, NY 14432 serves to enhance the commitment and collaboration between both organizations with the goal of assuring continuity and appropriateness of care for mutually served clients.

The intent of this agreement is to ensure that individuals and their families affected by Substance Use and Related Disorders receive comprehensive and coordinated services and linkage.

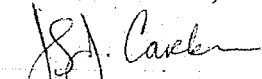
Principles:

1. Both parties agree to protect the confidentiality of the clients in accordance with Title 42 Part 2 of the Code of Federal Regulations, governing the Confidentiality of Substance Use Disorder Patient Records, as well as provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Both parties agree to make and receive appropriate and timely referrals, coordinate quality care and avoid duplication of services.
3. In the event both agencies are providing services concurrently, the agencies will provide appropriate communication of client progress, changes to client status or other critical information that is essential to service provision and quality of care, so long as all appropriate consents and/or authorizations have been received.
4. FLACRA agrees to refer clients for additional treatment outside the agency when the agency services preclude timely access to treatment; and/or when the client requests such services.
5. As a Center of Treatment Innovation (COTI), FLACRA agrees to provide evaluation and/or potential treatment services through the Outpatient Clinics, 820 Residential Treatment programming, Reentry/Incarceration Services, Addictions Crisis Services, Detox, Care Management, Housing and Community-Based Services, and/or the Mobile Response Unit. FLACRA also provides medication-assisted treatment, including methadone, through its licensed Opioid Treatment Program (OTP), the Certified Community Behavioral Health Clinics (CCBHC), and Community Recovery Centers.
6. **Yates County Public Health** include FLACRA in their referral source list for clients as an agency for additional and necessary services. **Yates County Public Health** will also provide services for clients referred by FLACRA when there is need of an additional service or level of treatment.

This agreement will be in effect from the date of execution and shall remain in effect for 1 year thereafter. Either party may terminate this agreement upon 30 days written notice to the other party via Registered Mail.

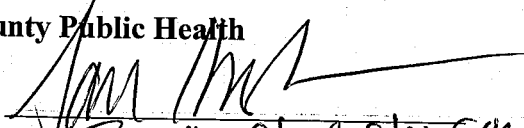
This agreement shall terminate immediately if either party fails to maintain existing licenses, certification, or accreditation in good standing. The parties agree to provide written notification of additions or deletions of services.

Jennifer Carlson, MPA


Chief Executive Officer
FLACRA

Date: 10/25/2025

Yates County Public Health

Signature: 

Printed Name: Sara Christensen

Date: 10/29/25



CoC NY-513 - FLACRA

2026 New Project Application Scoring Rubric

Applications are due July 15, 2026 by 5pm

Single Project Applications must be submitted in a single PDF via email to Bob Doeblin:

rdoeblin@genevaha.com

E-Snaps applications are due August 11, 2026 by 5pm

Agency and Project Information

Organization Name:	
Project Name:	

Contact Person Phone Number Email	

Amount Requesting	Projected Number of People Served
\$	

Project/Component Type (check correct box)

Permanent Supportive Housing (PSH)	☐
Rapid Rehousing (RRH)	☐
Transitional Housing (TH)	☐
Expansion Project for the above checked	☐
Support Services Only - Standalone (SSO)	☐

Support Services Only - Street Outreach (SSO)	☐
---	--------------------------

Threshold Requirements: All projects are required to meet or agree with these requirements to be considered for funding

The agency has reviewed all HUD priorities outlined on pages 106-108 of the NOFO and agrees to abide by them.	☐ Agree ☐ Disagree
Awards under this NOFO will not be used to engage in illegal racial discrimination, including racial preferences.	☐ Agree ☐ Disagree
Awards made under this NOFO will not be used to fund any project, service provider, or organization that operates illegal drug injection sites of “safe consumption sites” in violation of 21 U.S.C. § 856, knowingly permit the use or distribution of illicit drugs on property under their control in violation of 21 U.S.C. 856(a)(2), or knowingly distribute drug paraphernalia in violation of 21 USC 863. This is not a requirement that program participants must be sober in order to receive assistance, participate in treatment in order to receive assistance, or be evicted or exited from assistance for a first-time violation of a drug-related program policy or lease requirement.	☐ Agree ☐ Disagree
Awards under this NOFO will not be distributed in a way that violates or otherwise is used to interfere with constitutional protections guaranteed for speech and religious beliefs and the free exercise of religion.	☐ Agree ☐ Disagree
Pursuant to 2 CFR 200.332(b)(2), all agreements or contracts made with subrecipients under this NOFO must contain the same terms and conditions as those in the grant agreement issued by HUD. Any conflicting terms and conditions must be approved by HUD.	☐ Agree ☐ Disagree
Applicant is a non-profit organization, including a faith-based organization, with active 501(c)3 status, a public housing authority, a local government organization, or another eligible entity as specified in the NOFO. (Please see page 9 of the NOFO for a detailed listing of eligible applicants.)	☐ Yes ☐ No
If applying for TH (rental assistance), are you a local government, state government, or PHA, or partnering with one of these three entities to administer rental assistance funds?	☐ Yes ☐ No
Applicant agrees to uphold protections of VAWA (§ 5.2005 VAWA protections), including: confidentiality protections, use of emergency transfer plans, and regular staff training regarding VAWA.	☐ Yes ☐ No
Applicant agrees to use our Continuum’s Homeless Management Information System-HMIS (or comparable database if Domestic Violence-DV)	☐ Yes ☐ No

Applicant agrees to engage in technical assistance with FLACRA, when needed, and monthly program meetings to review data errors, case management documentation, services, utilization, spend down, and outcomes.	☐ Yes ☐ No
CoC Membership: The applicant has a current Memorandum of Understanding (MOU) with CoC NY-513 or is submitting an MOU with this application. (Templates will be posted on the CoC section of FLACRA's website.)	☐ Yes ☐ No
Applicant agrees to use the Coordinated Entry System to fill 100% of beds	☐ Yes ☐ No ☐ N/A
Applicant has attached the management letter from the agency's most recent fiscal audit demonstrating that the agency is in good standing.	☐ Yes ☐ No
Will the agency participate in the local Point In Time (PIT) Count?	☐ Yes ☐ No
Will the agency participate in half or more CoC subcommittee meetings in the past 12 months?	☐ Yes ☐ No
If your agency is applying for PSH, RRH, or TH funding, does your project have a kitchen and bathroom in the unit per HQS and NSPIRE standards? If not, do you intend to seek a waiver from HUD?	☐ Yes ☐ No If not, ☐ Yes ☐ No

If the answer is no to any of the above questions, please explain below, on the next page. (limit to 250 words)

If agency does not meet threshold requirements, stop scoring. Agency is not eligible for CoC funding.

Population(s) Served

Specialty Populations Served: (See pages 81-83 of the NOFO)	☐ Children and youth (3 pts) ☐ Families (2 pts) ☐ Veterans (2 pts) ☐ Survivors of domestic violence, dating violence,
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	sexual assault, and stalking (2 pts) ☐ Justice System Re-entry (2 pts) ☐ High utilizers of healthcare systems (2 pts) ☐ Aging and elderly (2 pts) ☐ Chronically homeless (CH) (2 pts)
Please describe the agency's unique ability to serve the above population(s) and share any relevant data to support your response. (Please limit to 250 words.) (5 pts)	
4-5 points: Discusses the population served and the agency's ability to best serve this population with the funding requested. Provides multiple data points to support response. Demonstrates a history of serving this population. 2-3 points: Limited description with limited data provided. 0-1 points: Population served description is not clear or fully thought out. No data is provided.	
Will the project require program participant engagement in supportive services (i.e., substance use and/or mental health treatment, etc.) as a condition of continued participation in the program? (5 pts)	☐ Yes ☐ No 4-5 points: Supportive service agreement provided. Addresses pathways to supportive services. 2-3 points: Limited description, no service agreement shared. 0-1 points: Will not require supportive services (for PSH/RRH only; TH is required).

Narrative Questions

Current, or Past Performance: 5 Points	If your agency currently receives, or has received Continuum of Care (CoC) funding in the past, have any of your programs fallen into Tier 2 or been reallocated? If yes, please describe why, and what changes have you implemented or plan to implement to ensure that this project meets the minimum HUD and CoC requirements?
4-5 points: Agency demonstrates experience operating housing programs, addresses any issues with past performance issues with plan to improve in the future. Application uses currently funded housing project data to demonstrate capacity. 2-3 points: Has some experience operating housing programs. 0-1 points: Agency has little or no experience operating housing programs.	
Program Design: 5 points	Describe how the type of housing or supportive services proposed. For housing, please include the number and configuration of units, where applicable, the needs of the program participants, and outline whether the project will be site-

	based or scattered-site. (please limit to 250 words) For supportive services, please provide a general description of the program, including the population served. Please indicate whether the project will serve any specialized populations. (please limit to 250 words)
4-5 points: Description of project aligns with program requirements. 2-3 points: Components are missing from program design or program design not well thought-out. 0-1 points: Narrative does not address design elements outlined in the question or critical information is lacking from narrative response.	
Supportive Services (PSH, RRH, TH only): 10 points	Describe how the project will assess participants' service needs and develop individualized service plans with them that provide tailored supportive services (except for eligible exemptions-over age 62, or defined in 24CFR8.3, or defined in 24CFR578.3) that are necessary to assist program participants to successfully obtain and retain permanent housing that fits their needs (such as transportation, safety planning, enhance case management) and are necessary to assist program participants to obtain and maintain long term housing stability (min 2 years post exit?) successfully exiting homelessness. ● Include how service plans will identify services, providers, frequency of service delivery, participant goals, strategies, and target dates related to health and wellness, housing stability, employment, financial stability, and self-sufficiency. If not on-site, provide the partnerships and corresponding MOUs for providing this care. ● For TH Project Only: How will your project ensure at least 20 hours per week of engagement in services, activities, education, training, volunteering, or employment. ● Expansion PSH, RRH only: If this is a PSH, or RRH expansion project also include how the project will expand supportive services to participants, including on-site supportive services where appropriate. (Please limit to 500 words)
8-10 points: Supportive services are provided on-site, agency policies demonstrate shared services for participants. Description is provided on how this occurs within the agency and shows history of care. 5-7 points: Supportive services are provided off-site, but MOUs and partnership agreements are shared with this application. Description of linkages is strong and shows history of care. 2-4 points: Supportive services will be provided off-site, no MOUs or partnership agreements are	

shared with this application. Can provide narrative of referrals. 0-1 points: Does not fully respond to the question, no MOUs or partnership agreements are shared, can't provide narrative of referrals, but can demonstrate a plan to provide this requirement.	
Supportive Services Continued (PSH, RRH, TH only): 5 points	Demonstrate that this project requires participation in supportive services per 24 CFR 578.75(h), including supporting agreement language, and ensuring VAWA protections under 24 CFR 5.2005(b)(1) are upheld.
5 points: Clearly outlines the supportive services participation, includes VAWA language, and has attached a copy or copies of the participant agreement(s). 3-4 points: Outlines services, includes VAWA language, but provides less detail or a less compelling argument 1-2-points: Gives minimal to basic information, lacks specificity or is not a compelling argument 0 points: No response, or the response does not address the question.	
Community and HUD Federal Need: 5 points	Using local data on homelessness, how does this project support CoC NY-513 and HUD's goal of ending homelessness for all persons? Please include the agency's unique ability to serve the population and share any relevant data to support your response. (please limit to 250 words)
4-5 points: Narrative uses local HMIS data to support project goals. Rationale for project is clearly related to HMIS data. Agency has demonstrated leadership in serving this population. 2-3 points: Either narrative does not use HMIS data OR Agency does not demonstrate evidence of leadership in serving population. 0-1 points: Narrative does not use HMIS/CoC NY 513 data AND agency does not demonstrate evidence of leadership in serving proposed population.	
Cost Effectiveness: 10 points	Demonstrate the average cost per household served for the project is reasonable according to 2CFR200.404. (please limit to 250 words)
10 points: Fully demonstrates cost reasonableness under 2 CFR 200.404. Clearly calculates the average cost per household and provides strong, transparent justification tied to program design, service intensity, staffing, and participant needs. Uses relevant comparisons (e.g., similar CoC projects, local market rates, housing/service costs, or prior performance data). Clearly shows costs are necessary, allocable, and efficient. 8-9 points: Provides a clear cost calculation and solid justification for reasonableness. May include some comparative or contextual data, but not fully comprehensive or deeply detailed. Strong alignment with allowable and necessary costs. 6-7 points: Includes the average cost per household and a general explanation of reasonableness. Some connection to program design or service needs is present, but limited supporting data or benchmarking. 4-5 points: Mentions cost per household but provides weak or generic justification. Limited explanation of why costs are reasonable under federal standards. Minimal context or supporting	

rationale. 2–3 points: Cost information is unclear, incomplete, or not meaningfully justified. Little to no connection to 2 CFR 200.404 reasonableness standard. 1 point: Provides minimal cost information and does not demonstrate any understanding of cost reasonableness requirements. 0 points: No response or does not address the question at all.	
Knowledge shared from persons who were homeless in the past: 5 points	How does your program involve people who were formerly homeless (i.e., employment/volunteer opportunities, peer support, mentorship, members of Board/Advisory Committees, etc.)? (please limit to 250 words)
4-5 points: Agency has one or more individual(s) involved with the program who has lived experience 2-3 points: Agency has plans, and can produce evidence of a plan, to ensure one or more individual(s) involved with the program has lived experience 0-1 points: Agency has no individuals involved with the program with lived experience.	
Minimizing Trauma Provision: 5 points	Describe how your program minimizes the trauma associated with homelessness. This could include trauma-informed care services and ensuring participant safety in programs, especially for youth and survivors of domestic violence, dating violence, sexual assault, and stalking. (please limit to 250 words)
4-5 points: Agency demonstrates the ability to minimize trauma as described in the question above. 2-3 points: Agency has plans, and can produce evidence of a plan, to ensure the program will minimize trauma as described in the question above. 0-1 points: Agency does not have the ability to provide this level of care and does not have a plan in place to provide this level of care.	

**The following 3 questions are project-type specific.
Complete only those that apply to this project application.**

PSH Projects only:

For PSH applicants, how will the project ensure that it is serving homeless individuals or families with a disability in accordance with 24 CFR 578.37(a)(1)(i) (5 points)
5 points: Clearly describes a compliant, well-defined process to ensure all participants meet both homelessness eligibility and disability documentation requirements under 24 CFR 578.37(a)(1)(i). Includes specific screening procedures at intake, use of HMIS or coordinated entry verification, required disability documentation sources (e.g., third-party verification, medical records, disability benefits), staff roles responsible for eligibility review, and ongoing compliance monitoring. Demonstrates strong understanding of HUD eligibility rules and prevents ineligible admissions. 4 points: Describes eligibility screening and disability verification processes that are generally compliant. Covers key elements (homeless verification, disability documentation, intake procedures),

but may lack detail on documentation standards, staff oversight, or ongoing monitoring.

3 points: Provides a basic description of intake and eligibility checks, including homelessness and disability, but processes are general or incomplete. Limited detail on documentation requirements or compliance safeguards.

2 points: Mentions eligibility requirements but provides vague or unclear procedures for verifying homelessness or disability. Weak or missing explanation of documentation standards or compliance controls.

1 point: Minimal response that does not meaningfully explain how eligibility will be verified or how compliance with the regulation will be ensured.

0 points: No response or does not address the question.

RRH Projects only:

For RRH projects: Please describe how the provision of tenant-based rental assistance will help individuals and families achieve and maintain self-sufficiency within 24 months. (5 points)

5 points: Clearly explains how TBRA supports rapid housing stability and long-term self-sufficiency within 24 months. Describes a structured approach to subsidy reduction or transition (if applicable), coordinated supportive services, and individualized goal planning (e.g., employment, income growth, benefits acquisition). Demonstrates how participants will increase income, reduce reliance on assistance, and maintain housing independently. Includes specific service strategies, timelines, and measurable outcomes tied to self-sufficiency.

4 points: Describes how TBRA promotes housing stability and self-sufficiency, with some discussion of supportive services and participant goals. May lack detailed timelines, measurable outcomes, or clear transition planning.

3 points: Provides a general explanation of how TBRA helps participants maintain housing and work toward independence, but limited detail on structure, services, or the 24-month self-sufficiency expectation.

2 points: Mentions housing assistance and self-sufficiency but does not clearly explain how TBRA leads to independence within 24 months. Weak or missing discussion of services or outcomes.

1 point: Minimal response with little connection between TBRA and self-sufficiency goals.

0 points: No response or does not address the question.

TH and RRH Projects only:

TH and RRH: Please describe the success of your agency's current housing program(s) in helping homeless individuals and families exit homelessness within 24 months or describe how your agency plans to ensure that individuals and families exit homelessness within 24 months. (please limit to 250 words) (5 points)

5 points: Clearly demonstrates strong performance or a well-defined plan to achieve exits from homelessness within 24 months. If describing current programs, includes specific outcomes (e.g., housing placement rates, average time to housing, retention rates, or exit destinations). If describing future approach, provides a structured strategy with clear timelines and measurable performance targets. Shows strong alignment between services, case management, and housing outcomes.

4 points: Provides a clear description of program success or strategy with some outcome data or performance indicators. May lack depth in metrics, specificity in timelines, or detailed explanation of how success is achieved.

3 points: Offers a general description of housing program success or planned approach. Limited or no concrete performance data, and strategy for achieving 24-month exits is broad or partially developed.

2 points: Mentions housing assistance or goals but provides little evidence of success or a weak/unclear plan for ensuring 24-month exits.

1 point: Minimal response with little connection to housing outcomes or 24-month exit requirement.

0 points: No response or does not address the question.

SSO - Street Outreach Projects only:

Encampments: (4 points)	Describe how the applicant will assist with efforts to quickly clear tents and encampments on public property and connect individuals who are camping in public with appropriate services. (please limit to 250 words)
4 points: Response provides a comprehensive, well-developed strategy for assisting with encampment resolution through coordinated outreach and engagement. Clearly describes how individuals will be identified and engaged, connected to housing, emergency shelter, behavioral health, and other supportive services, and transitioned from encampments to stable housing. Demonstrates strong partnerships with local governments and service providers, includes a participant-centered approach, and provides evidence of organizational capacity or prior success. 2-3 points: Response adequately addresses the prompt and describes a clear outreach and service connection strategy. Includes coordination with partners and identifies key supportive services, but lacks detail, specificity, or evidence in one or more areas. 0-1 points: Response may partially address the prompt but provides only a general or limited description of outreach, service coordination, or housing connection strategies. Omits several important elements or lacks a clear implementation plan.	
Illicit Drug Use: (4 points)	Describe how the applicant will assist with efforts to decrease the public use of illicit drugs and quickly connect individuals who are using illicit drugs in public with appropriate services and/or law enforcement. (please limit to 250 words)
4 points: Response provides a comprehensive, well-developed strategy for reducing public illicit drug use through coordinated outreach, engagement, and rapid connection to appropriate services. Clearly describes how individuals will be identified and connected to behavioral health treatment, substance use disorder services, crisis intervention, housing, and other supportive services, as appropriate. Explains coordination with law enforcement, first responders, and community partners when appropriate, while demonstrating a participant-centered, evidence-informed approach and	

organizational capacity to implement the strategy. 2-3 points: Response adequately addresses the prompt and describes a clear strategy for connecting individuals to appropriate services and coordinating with law enforcement or community partners. The response is well organized but lacks detail, specificity, or supporting evidence in one or more areas. 0-1 points: Response may partially address the prompt but provides only a general description of outreach, service coordination, or law enforcement collaboration. Omits several important elements or lacks a clear implementation plan for reducing public illicit drug use and connecting individuals to services.	
Addressing Immediate Danger: (3 points)	Describe how the applicant will assist with efforts to address homeless individuals who are a danger to themselves or others (e.g., involuntary commitment). (please limit to 250 words)
3 points: Response provides a comprehensive, well-developed strategy for identifying and responding to homeless individuals who may be a danger to themselves or others. Clearly describes coordination with behavioral health providers, crisis response teams, emergency medical services, and/or law enforcement, as appropriate. Explains procedures for crisis intervention, referral to treatment, involuntary commitment when legally appropriate, and connection to ongoing housing and supportive services. Demonstrates organizational capacity and strong partnerships to implement the proposed approach. 2 points: Response addresses the prompt but lacks some detail or specificity to their strategy. Describes some coordination with behavioral health providers, crisis responders, or law enforcement but lacks sufficient detail regarding implementation, partnerships, referral processes, or ongoing service coordination. 1 point: Response provides only a general or partially developed strategy. Fails to describe a meaningful strategy for responding to homeless individuals who may be a danger to themselves or others or does not adequately address coordination, crisis intervention, or connection to appropriate services. 0 points: Response is incomplete, vague, or largely nonresponsive.	
Sharing Information: (3 points)	Describe how the applicant will assist with efforts to comprehensively share information, including location information, in accordance with the Sex Offender Registry and Notification Act (SORNA). (please limit to 250 words)
3 points: Response provides a comprehensive, well-developed plan for sharing information, including location information, in accordance with SORNA requirements. Clearly describes coordination with law enforcement, corrections, and other relevant agencies; outlines procedures for timely, accurate, and legally compliant information sharing; demonstrates strong interagency collaboration; and provides evidence of organizational capacity to implement the proposed approach. 2 points: Response adequately addresses the prompt and describes a clear approach to information sharing and coordination with partner agencies. Demonstrates an understanding of SORNA-related responsibilities but lacks detail, specificity, or supporting evidence in one or more areas. 1 point: Response partially addresses the prompt but provides only a general or limited description of	

information sharing practices. Omits several important elements, such as implementation procedures, coordination with relevant agencies, or compliance considerations. 0 points: Response is incomplete, vague, or largely nonresponsive. Fails to describe a meaningful strategy for sharing information in accordance with SORNA or does not adequately address coordination, legal compliance, or implementation.	
Agency History and Experience with Outreach: (5 points)	Describe your agency's history of experience providing outreach services, or a plan for providing outreach services, consistent with the activity description at 24 CFR 578.53(e)(13) and has a plan for or has demonstrated effectiveness at helping people successfully exit from places not meant for human habitation to emergency shelter, treatment programs, transitional housing, or permanent housing programs. (please limit to 250 words)
4-5 points: Describes a strong history of providing outreach services with clear data to support their success or presents a well-developed and comprehensive plan to provide outreach services, shown to be consistent with 24 CFR 578.53(e)(13). Provides clear evidence of effectiveness at helping people successfully exit from places not meant for human habitation or presents a well-developed and comprehensive plan to do so. 2-3 points: Describes a history of providing outreach services but has limited experience and success or presents a plan that lacks specificity and detail. Discusses prior experience or a plan to exit people from places not meant for human habitation but fails to show evidence that they will be successful. 0-1 points: Has no history of providing outreach services and does not have an adequate plan. Does not address how to help people exit from places not meant for human habitation or describes a plan in contradiction to 24 CFR 578.53 (e)(13).	
Participant Engagement: (5 points)	Describe the proposed project's strategy for providing supportive services to eligible program participants, including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services. (please limit to 250 words)
4-5 points: Provides a comprehensive, well-developed strategy for providing supportive services. Specifically presents a clear strategy for engagement of clients with histories of unsheltered homelessness and those who do not traditionally engage with supportive services. 2-3 points: Provides a strategy for providing supportive services, but plan lacks specificity or detail. Discusses serving clients with histories of unsheltered homelessness and those who do not traditionally engage with supportive services, but fail to specifically show that they have an adequate plan for serving this population. 0-1 points: Does not provide a strategy and does not address participants with histories of unsheltered homelessness or those who do not traditionally engage with supportive services.	
First Responder and Law Enforcement Engagement: (1 point)	Describe your agency's history of, or plan for, partnering with first responders and law enforcement to engage people living in places not meant for human habitation to access emergency shelter, treatment programs, reunification with family, transitional housing, or independent living. Please describe how your agency intends to cooperate and not interfere or impede with the enforcement of

	local laws such as public camping and public drug use laws and assist/be willing to assist first responders in their efforts to engage homeless individuals. (please limit to 250 words)
1 point: Demonstrates a history of strong partnership with law enforcement or clearly describes a well-developed plan for partnering with law enforcement to support people living in places not meant for human habitation. Describes how they will cooperate and not interfere with enforcement of local laws. 0 points: Does not demonstrate a history of or a plan to work with law enforcement. Does not indicate how they will not interfere with enforcement of local laws.	

SSO - Standalone Projects only:

Project need 10 points	Using local data on homelessness and other data, please describe why your agency believes the project is necessary to assist people in exiting homelessness, addressing barriers to stable housing (e.g., substance use disorder, unemployment, childcare, etc.) and increasing self-sufficiency.
9-10 points: Provides a compelling, data-driven justification using multiple, current local data sources on homelessness and related community needs. Clearly explains why the project is necessary, demonstrates a strong understanding of local gaps, and explains how the project will increase housing stability and self-sufficiency. 7-8 points: Includes relevant local data and explains the need for the project. Some opportunities exist to strengthen the use of evidence or the connection between identified needs and project activities. 4-6 points: Addresses the prompt but uses minimal or outdated local data. Identifies barriers without fully explaining their impact or how the project addresses them. 0-3 points: Minimal response with vague statements about homelessness. Lacks meaningful data, analysis, or explanation of community needs. Does not adequately connect the project to identified barriers.	
Relationships 10 points	Describe your relationship with shelters and street outreach providers in Ontario, Seneca, Wayne, and Yates Counties, and how this relationship would improve your ability to provide support services to the target population to assist them in exiting homelessness. Please provide MOUs.
9-10 points: Provides a comprehensive description of established relationships with shelters and street outreach providers in Monroe County/City of Rochester. Clearly explains the nature of collaboration and how these partnerships strengthen the agency's ability to help clients exit homelessness and access support services. Includes signed, current MOUs or letters of commitment that clearly define roles and responsibilities.	

7-8 points: Identifies key shelter and outreach partners and explains how collaboration supports the target population. Includes required MOUs, but provides limited detail about coordination, referral processes, or measurable benefits to clients. 4-6 points: Provides a general description of community relationships without demonstrating how they improve service delivery; MOUs may be outdated, incomplete, or only partially address the proposed project. 0-3 points: Limited response with little evidence of established relationships or coordination. Few specifics and no meaningful documentation of partnerships. Does not clearly explain how partnerships support clients exiting homelessness.	
Assessment 5 points	Please provide a copy of the assessment tool that you intend to use to evaluate the initial and ongoing service needs of program participants. Use this space to provide any details about the assessment.
4-5 points: Provides a copy of an appropriate and relevant assessment tool. Clearly explains how they will use the tool to evaluate initial and ongoing needs and explains how it will benefit staff and participants. 2-3 points: Provides a copy of an assessment tool but fails to clearly show why the tool is an appropriate choice or how it will effectively support the needs of staff and participants. 0-1 points: Does not provide an assessment tool or provides a tool that is not related to evaluating the initial and ongoing needs or program participants.	
Strategy 10 points	What is the proposed strategy for providing supportive services to eligible program participants, including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services? Please include your agency's history of ability to successfully serve this population.
9-10 points: Response provides a comprehensive, well-developed strategy for supportive services. Describes how the project will specifically be able to support participants with histories of unsheltered homelessness and those who do not traditionally engage with supportive services. Provides a strong history of serving the target population with measurable evidence of success. 7-8 points: Response addresses most components of the prompt with adequate detail. Strategy and agency experience are generally well described but may lack depth, evidence, or specificity in one or two areas. 4-6 points: Response partially addresses the prompt but lacks sufficient detail regarding supportive services, target populations, or agency experience. Limited evidence of successful implementation is provided. 0-3 points: Response addresses only a small portion of the prompt with little explanation or supporting information.	
Supplemental Resources: 5 Points	Describe how your project will be supplemented with resources from other public or private sources, that may include mainstream health,

	social, and employment programs such as Medicare, Medicaid, SSI, and SNAP in order to create self-sufficiency and economic independence. Include MOUs/partnership agreements.
4-5 points: Response clearly explains how a wide variety of external resources will be integrated into the project and how these will lead to self-sufficiency and economic independence. Includes signed, current MOUs or letters of commitment that clearly define roles and responsibilities. 2-3 points: Demonstrates a plan for supplementing the project with external resources but lacks specific details about these partnerships or has limited other partners. Includes required MOUs, but provides limited detail about coordination, referral processes, or measurable benefits to clients. 0-1 points: Does not have a clear plan for how this project will be supplemented with other resources. Few specifics and no meaningful documentation of partnerships. 4-5 points: Response demonstrates a clearly thought-out plan for how the project will be supplemented with a wide variety of other public and private sources. A clear rationale is explained for how the chosen sources will support the program and how linkages will be made. 2-3 points: Response describes a plan for how some external resources will be used to supplement the project, but resources are limited or insufficient. The benefit of the resources listed is not clearly explained. 0-1 points: Response does not provide a plan for how to supplement the project with external resources.	

Performance Measures All Applicants:

Data Quality: 2 points	Describe your commitment to timely data submission and data quality in coordination with the Continuum of Care (CoC).
2 points: Clearly demonstrates a strong commitment to timely and accurate HMIS/data submission in coordination with the CoC. Describes specific procedures for data entry timelines (e.g., real-time or within required CoC standards), data quality monitoring (e.g., routine audits, validation reports, error correction processes), staff roles responsible for data entry and oversight, and participation in CoC data quality initiatives or training. Shows understanding of HMIS requirements and continuous improvement of data accuracy and completeness. 1 point: Indicates general commitment to timely data submission and data quality, but provides limited detail on procedures, timelines, or accountability. Mentions HMIS or CoC coordination but lacks specifics on how data quality is ensured or maintained. 0 points: No meaningful response or does not address timely data submission or data quality in relation to the CoC/HMIS requirements.	
Employment & Income Growth: 10 points	Describe how a minimum of 25% of clients will obtain employment income to maximize their ability to live independently. Has your agency operated a homeless program where at least 50%

	exited with employment income as reflected in HMIS? Or is there a plan to ensure these same outcomes? (please limit to 250 words)
8-10 points: Agency describes their ability and commitment to helping clients in obtaining employment and income resources 5-7 points: Specific strategies are named, but do not include all resource areas. 2-4 points: All three resource areas are described, but specific strategies are not described. Strategies are vague. 0-1 points: Answer is not applicable to the question or does not give any detail.	
Supplemental Resources: 5 points	Describe how your agency plans to supplement this project with resources from other public or private sources, such as mainstream health, social, and employment programs, such as Medicare, Medicaid, SSI, and SNAP?
5 points: Clearly describes a well-developed and proactive strategy to connect participants with mainstream and community resources. Includes specific programs (e.g., Medicaid, SSI/SSDI, SNAP, TANF, workforce programs), and explains how staff will assist with enrollment, eligibility determination, referrals, and ongoing access. Demonstrates strong coordination with external agencies and may include MOUs or formal partnerships. Shows how leveraging these resources reduces CoC funding reliance and improves housing stability and self-sufficiency. 4 points: Describes a solid plan to connect participants to mainstream benefits and services, with some detail on referral processes or partnerships. May lack specificity on implementation steps or coordination mechanisms. 3 points: Provides a general description of referrals to mainstream services but limited detail on how enrollment or ongoing access will be ensured. Weak explanation of coordination or system integration. 2 points: Mentions mainstream resources but provides minimal explanation of how participants will be connected to or supported in accessing them. 1 point: Minimal response with little meaningful description of leveraging external resources. 0 points: No response or detail.	
Supportive Service Provision: 10 points	Describe how this project will provide the treatment and services that people need to recover and regain self-sufficiency (including on-site behavioral health treatment, robust wraparound supportive services, and participation requirements for these services). Provide the partnerships and corresponding MOUs for providing this care. (please limit to 250 words)
7-10 points: Agency has actionable practices to provide ongoing supportive services throughout the duration of the project. Examples of practices include centering the participant in goal planning, creative engagement strategies, and case management training. 4-6 points: Agency provides supportive services but has limited examples of specific practices.	

0-3 points: Agency does not have a clear strategy for providing ongoing services.	
Returns to Homelessness: 10 points	How will this project ensure that clients will not return to homelessness within two years after project exit? Describe your plan to ensure minimal to no exits with unknown destinations. (please limit to 250 words)
8-10 points: Describes agency practices relating to supportive services and stability plans. Agency has 'moving on' strategies to ensure participants are stable at program exit. Agency addresses how it will ensure participants have long-term stability including access to ongoing supportive services, affordable housing/subsidies, etc. 5-7 points: Agency describes commitment to ensuring participants do not return to homelessness but strategies are unclear or limited. Agency has limited experience in stabilizing clients. 2-4 points: Agency commits to ensuring participants will not return to homelessness but does not give any concrete details. 0-1 points: Answer is not applicable to the question or does not give details.	

TH and RRH Project Applicants Only:

TH and RRH Only: Does your agency currently, or has it previously operated a TH, RRH, or other homeless project where at least 50% of participants exited to a positive destination within 24 months, and at least 50% exit with employment income as reflected in HMIS? Or is there a plan to ensure these same outcomes? Please describe. (250 word limit)
10 points: Clearly demonstrates strong historical performance meeting or exceeding both benchmarks (≥50% positive exits within 24 months and ≥50% employment income exits) with HMIS data or credible performance reporting. If no history, provides a detailed, realistic, and evidence-based plan to achieve these outcomes. Includes specific strategies such as housing stabilization services, employment supports, partnerships (workforce agencies, employers), coordinated entry alignment, and strong case management. Clearly explains tracking methods, performance monitoring, and continuous improvement. 8-9 points: Shows strong performance history or a well-developed plan likely to meet both benchmarks. Includes relevant strategies and some data or metrics, but may lack full HMIS specificity, depth of benchmarking, or detailed monitoring systems. 6-7 points: Provides either partial performance evidence or a general plan. Mentions key strategies for housing and employment outcomes but lacks strong data, specificity, or clear assurance of meeting both benchmarks. 4-5 points: Provides minimal performance information or a basic plan. Limited connection to achieving both required thresholds. Weak detail on employment and housing exit strategies or performance tracking. 2-3 points: Response is vague, lacks credible performance data, and does not clearly explain how outcomes will be achieved. Minimal understanding of required benchmarks.

1 point: Does not meaningfully address performance history or outcomes plan.
0 points: No response or does not address the question.

For Reviewer Use Only

Applicant Budget submitted is feasible, cost-effective, and allowable. (5 points)	☐ Yes ☐ No
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CoC NY-513 - FLACRA

2026 Renewal Project Application Scoring Rubric

Applications are due July 15, 2026 by 5pm

Single Project Applications must be submitted in a single PDF via email to Bob Doeblin:

rdoeblyn@genevaha.com

E-Snaps applications are due August 11, 2026 by 5pm

Organization Name:	
Project Name:	

Contact Person	
	Phone Number
	Email

Project Type (check correct box)	
Transitional housing – Rapid Re-Housing (TH-RRH)	
Permanent Supportive Housing (PSH)	

Renewal Competition Selection: (contact Jessica to schedule a time to speak to the CoC asap)	☐ Submit project as it exists now for renewal in the local competition ☐ Use transition grant option to switch to Transitional Housing Project component, please use this application to apply as the project component type that you intend to change it to. ☐ Self-reallocate all funds
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Threshold Requirements:

All projects are required to meet or agree with threshold requirements to be considered for funding.

The agency has reviewed all new HUD priorities outlined in the NOFO	☐ Yes ☐ No
Awards under this NOFO will not be used to engage in illegal racial discrimination, including racial preferences.	☐ Agree ☐ Disagree
Awards under this NOFO will not be distributed in a way that violates or otherwise is used to interfere with constitutional protections guaranteed for speech and religious beliefs and the free exercise of religion.	☐ Agree ☐ Disagree
Awards made under this NOFO will not be used to fund any project, service provider, or organization that operates illegal drug injection sites of “safe consumption sites” in violation of 21 U.S.C. § 856, knowingly permit the use or distribution of illicit drugs on property under their control in violation of 21 U.S.C. 856(a)(2), or knowingly distribute drug paraphernalia in violation of 21 USC 863. This is not a requirement that program participants must be sober in order to receive assistance, participate in treatment in order to receive assistance, or be evicted or exited from assistance for a first-time violation of a drug-related program policy or lease requirement.	☐ Agree ☐ Disagree
Pursuant to 2 CFR 200.332(b)(2), all agreements or contracts made with subrecipients under this NOFO must contain the same terms and conditions as those in the grant agreement issued	☐ Agree ☐ Disagree

by HUD. Any conflicting terms and conditions must be approved by HUD.	
Applicant is a non-profit organization, including a faith based organization, with active 501(c)3 status, a public housing authority, a local government organization, or another eligible entity as specified in the NOFO.	☐ Agree ☐ Disagree
Applicant agrees to uphold protections of VAWA (§ 5.2005 VAWA protections) including: confidentiality protections, use of emergency transfer plans, and regular staff training regarding VAWA.	☐ Agree ☐ Disagree
Applicant agrees to engage in technical assistance with FLACRA when needed and monthly program meetings to review data errors, case management documentation and services, utilization, spend down, and outcomes.	☐ Agree ☐ Disagree
Applicant has attached the management letter from the agency's most recent fiscal audit demonstrating that the agency is in good standing.	☐ Agree ☐ Disagree
CoC Membership: The applicant has a current Memorandum of Understanding (MOU) with CoC NY-513 or is submitting an MOU with this application. (Templates will be posted on the CoC section of FLACRA's website.)	☐ Agree ☐ Disagree

If agency does not meet threshold requirements, stop scoring. Agency is not eligible for CoC funding.

Population(s) served:

Specialty Populations Served	☐ Children and youth (3 pts) ☐ Families (2 pts) ☐ Veterans (2 pts) ☐ Survivors of domestic violence, dating violence, sexual assault, and stalking (2 pts) ☐ Justice System Re-entry (2 pts) ☐ High utilizers of healthcare systems (2 pts) ☐ Aging and elderly (2 pts) ☐ Chronically homeless (CH) (2 pts)
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Please describe the agency's unique ability to serve the above population(s) and share any relevant data to support your response. (Please limit to 250 words.) (5 pts)	4-5 points: Discusses the population served and the agency's ability to best serve this population with the funding requested. Provides multiple data points to support response. Demonstrates a history of serving this population. 2-3 points: Limited description with limited data provided. 0-1 points: Population served description is not clear or fully thought out. No data is provided.
Will your project require program participant engagement in supportive services (i.e., substance use and/or mental health treatment, etc.) as a condition of continued participation in the program? (5 pts)	☐ Yes ☐ No 4-5 points: Supportive service agreement provided. Addresses pathways to supportive services. 2-3 points: Limited description, no service agreement shared. 0-1 points: Will not require supportive services (for PSH/RRH only; TH is required).

Narrative Response Questions

Supportive Service Provision (10 points)	Describe how your project provides the treatment and services that people need to recover and regain self-sufficiency (including on-site behavioral health treatment, robust wraparound supportive services, and participation requirements for these services). If not on-site, provide the partnerships and corresponding MOUs for providing this care. (please limit to 250 words)
If you are applying for a transition grant to change your project component to a Transitional Project, describe how the project will meet service provision requirements. If you are applying for a renewal project to keep your current component type in the competition, describe how your project will implement service agreements. 8-10 points: Supportive services are provided on-site, agency policies demonstrate shared services for participants. Description is provided on how this occurs within the agency and shows history of care. 5-7 points: Supportive services are provided off-site, but MOUs and partnership agreements are shared with this application. Description of linkages is strong and shows history of care. 2-4 points: Supportive services will be provided off-site, no MOUs or partnership agreements are shared with this application. Can provide narrative of referrals. 0-1 points: Does not fully respond to the question, no MOUs or partnership agreements are shared, can't provide narrative of referrals, but can demonstrate a plan to provide this requirement.	
Knowledge shared from persons who were previously or currently homeless (5 points)	How will or how does your program involve people who were formerly homeless? (i.e., employment/volunteer opportunities, peer support, mentorship, members of Board/Advisory Committees,

	etc.) (please limit to 250 words)
4-5 points: Agency has one or more individual(s) involved with the program who has lived experience 2-3 points: Agency has plans, and can produce evidence of a plan, to ensure one or more individual(s) involved with the program has lived experience 0-1 points: Agency has no individuals involved with the program with lived experience.	
Minimizing Trauma (5 points)	Describe how your program minimizes the trauma associated with homelessness. This could include trauma informed care services, ensuring participant safety in programs, especially for youth and survivors of domestic violence, dating violence, sexual assault, and stalking. (please limit to 250 words)
4-5 points: Agency demonstrates the ability to minimize trauma as described in the question above. 2-3 points: Agency has plans, and can produce evidence of a plan, to ensure the program will minimize trauma as described in the question above. 0-1 points: Agency does not have the ability to provide this level of care and does not have a plan in place to provide this level of care.	
Addressing the Goals of the NOFO (10 points)	How will your project advance the goals described in the NOFO? (Beginning on page 28) This includes optimizing self-sufficiency, reducing homelessness, prioritizing treatment and recovery, advancing public safety, and minimizing the trauma caused to communities as a whole by homelessness.
8-10 points: Agency demonstrates the ability, capacity, and prior experience to improve outcomes as stated in the question and can demonstrate this through data, policies, and any other relevant narrative. 5-7 points: Components of the response are missing and the response is limited (i.e., data is not provided, policies are not provided, etc.). 3-6 points: Agency has plans, and can produce evidence of a plan, to ensure the program will improve outcomes as described in the question above. Much ability, capacity, and prior experience narrative is missing. 2-0 points: Agency does not have the ability to improve outcomes and does not have a plan in place to improve outcomes as described in the question above.	

All performance data is for 10/1/24-9/30/25.

Financial data is for the most recently completed Fiscal Year.

Monitoring score is for the most recent monitoring visit.

Utilization: 10 points 3 points for utilization rate $\geq 85\%$ in 2023 3 points for utilization rate $\geq 85\%$ in 2024 3 points for utilization rate $\geq 85\%$ in 2025 1 bonus point if $\geq 85\%$ all three years	Projected households served during average PIT: _____ Utilization rate from APRs: 2023: 2024: 2025: Households Average Actual/ Projected = Utilization %
Data Quality: 10 points 2 points for each	Were the following error rates below 5% for APR Q6 from 10/1/24-9/30/25? Personally, Identifying Information (6a) ☐ Yes ☐ No Universal Data Elements (6b) ☐ Yes ☐ No Income and Housing Data Quality (6c) ☐ Yes ☐ No Chronic Homelessness (6d) ☐ Yes ☐ No Were 95% of entries added into HMIS within 72 hours or less? (6e) ☐ Yes ☐ No
Permanent Housing Placement & Retention: 10 points For PSH, 4 points if $\geq 93\%$ For RRH, 4 points if $\geq 50\%$ 6 points if $\geq 20\%$	For PSH, what percentage of clients served from 10/1/24-9/30/25 either stayed in the project or exited to a permanent housing destination? (APR Q5a#8 Stayers, Q23c Exiting to housing destinations) Equation to use: (Positive housing destinations + Stayers) / (Total Participants – Persons excluded) For RRH, of the clients who exited your project from 10/1/24-9/30/25, what percentage exited to a permanent housing destination? (APR Q23c) For all projects, what percentage of exits from 10/1/24-9/30/25 were to unsubsidized housing? (APR 23c – “Rental by client, no ongoing housing subsidy” or “Owned by client, no ongoing housing subsidy.”)
Employment Income Growth: 10 points 5 points if $\geq 20\%$	What percentage of clients enrolled in your program from 10/1/24-9/30/25 increased their employment income (APR Q19a1 and Q19a2)? What percentage of clients who exited your

5 points if $\geq 25\%$	program from 10/1/24-9/30/25 exited with an increase in employment income? (Within the “Number of Adults with Earned Income” Rows in Q19a1 & 19a2) Adults who Gained or Increased Income from Start to Annual Assessment, Average Gain + Adults who Gained or Increased Income from Start to Exit, Average Gain/Total Adults in Q19a1 + Total Adults in Q19a2
Returns to Homelessness: (FLACRA will calculate this) 10 points 5 points if $\leq 7\%$, 2 points if $\leq 11\%$ 5 points if $\leq 8\%$, 2 points if $\leq 16\%$	Percentage of those exiting to permanent housing between 10/1/22-9/30/2023 that returned to homelessness in two years or less. Percentage returning to homelessness within 1 year: _____ Percentage returning to homelessness within 2 years: _____
Self-Sufficiency: 5 points (page 61)	Describe assessments that your agency uses with your clients to develop a service plan that helps to increase self-sufficiency and leads to long term economic independence. Describe how these assessments have shown improvement in these areas over time.
4-5 points: Description of service plan and corresponding assessments is aligned with program requirements and show the ability to increase self-sufficiency, economic independence, and long-term improvement. 1-3 points: Components are missing from service plan or assessment description and/or not well thought-out and/or does not show improvement. 0 points: No service plan or assessment description provided.	
APR Submission: 4 points 1 point if “Yes” for 2023 1 point if “Yes” for 2024 1 point if “Yes” for 2025 1 bonus point if “Yes” for all three years	Was the project’s APR submitted on time for the following years? 2023 ☐ Yes ☐ No 2024 ☐ Yes ☐ No 2025 ☐ Yes ☐ No
Monitoring: 5 points	Were there significant findings for your project during CoC (both HUD and local CoC) monitoring

Yes – 5 points No – 0 points	over the last three years? ☐ Yes ☐ No
Drawdown Efficiency: (7 points) 5 points if $\geq 95\%$ 2 points if “Yes”	What percentage of HUD expenditures were drawn down from the project's APR for the year ending 2025? Did the project draw down funds at least once per quarter for the year ending 2025? ☐ Yes ☐ No
Cost of Success rate: (10 points) For PSH Projects Only: In Sage, in the box on right Performance Spotlight click the Positive Housing percentage that coincides with the correct grant year. Put Total Stayers under Remained In Housing. For RRH, TH Projects Only: In Sage, in the box on right Performance Spotlight click the Utilization percentage that coincides with the correct grant year. Put Total Units In Grant under Remained In Housing. Below 1 standard deviation from mean=10 points Within 1 standard deviation of mean=5 Greater than 1 standard deviation from mean=0 points OR <5,000=10 points 5-7,000=7 points Average=5 points (7-8,000) 8-10,000=3 points >10,000=0 points	HUD grant amount divided by the number of households with a successful exit or remained stable in PH from the 10/1/2024 - 9/30/2025 APR:
Participation in the CoC: (5 points) 100% participation - 5 points 75% participation - 4 points 50% participation - 3 points 25% participation - 2 points 0% participation - 0 points	Did the agency participate in half or more CoC or subcommittee meetings in the past 12 months? ☐ Yes ☐ No

The Agency takes 100% of referrals from CE if receiving rental assistance or leasing funds (5 points) 5 points – Yes or N/A 0 points – No	☐ Yes or N/A ☐ No
Mitigating Factors: Please explain any outcomes that you think do not accurately portray your program or anything you want the reviewers to know about your program not covered in the application questions. (Please be specific and keep the word count total under 500 words) (5 points)	

Total score: ____/____148____

**NY-513 Continuum of Care Local Competition
Final Ranking**

Tier	Ranking	Application Score	Agency Name	Project Name	Project Type	Project Status	Renewal / New	CoC Funding Requested	Reallocated Funds +/-
Tier 1									
	1	Not scored per CoC policies	Finger Lakes Area Counseling & Recovery Agency	HMIS	HMIS	Accepted	Renewal	\$22,176.00	-
	2	127	Finger Lakes Area Counseling & Recovery Agency	Wayne County Permanent Supportive Housing	PSH	Accepted	Renewal	\$140,494.00	-
	3 (straddles)	121	Finger Lakes Area Counseling & Recovery Agency	Transitional Housing	TH	Accepted	New	\$71,290.00	+\$48,123.00*
Tier 2									
	3 (straddles)	121	Finger Lakes Area Counseling & Recovery Agency	Transitional Housing	TH	Accepted	New	\$103,947.00	-
	4	118	Finger Lakes Area Counseling & Recovery Agency	Shelter Plus Care for the Chronically Homeless	PSH	Accepted	Renewal	\$179,140.00	-
Reallocated									
	N/A	N/A - reallocated prior to ranking	Wayne County Action Program, Inc.	Success Center TH-RRH	Joint TH-RRH	Fully Reallocated	Renewal	\$0.00	-\$48,123.00
Unranked									
	N/A	N/A	Finger Lakes Area Counseling & Recovery Agency	Planning Grant		Accepted	New	\$80,845.00	-
			Totals						\$597,892

Total Amount Requested from HUD	\$597,892.00
Estimated ARD	\$389,933.00
PPRN	\$1,616,907.00
FPRN	\$1,616,907.00
DV Bonus	\$323,381.00
CoC Bonus	\$500,000.00
CoC Planning	\$80,845.00
UFA Costs	\$48,507.00
Tier 1	\$233,960.00

NY-513 CONTINUUM OF CARE

Statement to Advance Recovery and Self-Sufficiency

Purpose

The NY-513 Continuum of Care (CoC) is committed to ensuring that housing assistance is paired with meaningful supportive services that promote recovery, housing stability, self-sufficiency, and successful transition from homelessness to long-term housing stability.

Statement

NY-513 recognizes that individuals and families experiencing homelessness have different needs and that recovery and self-sufficiency are individualized processes. CoC-funded housing projects will assess participant needs and connect participants to appropriate supportive services. Services may include case management, mental health services, substance use disorder treatment and recovery supports, physical healthcare, peer support, employment and vocational services, education, benefits assistance, life-skills development, transportation, care management, and other services necessary to support housing stability and independence.

Supportive Service Participation

CoC-funded housing projects will establish meaningful supportive-service participation expectations consistent with applicable HUD requirements. Individualized Service Plans will be used to identify participant goals, appropriate services and activities, responsible providers, and progress toward housing stability and self-sufficiency.

Treatment, Recovery, and Wellness

When mental health treatment, substance use disorder treatment, recovery services, or other clinical supports are identified as appropriate through assessment, clinical recommendation, or an Individualized Service Plan, projects will facilitate access to those services and support continued engagement. Individuals who do not have an identified substance use disorder will not be required to participate in substance use disorder treatment solely as a condition of receiving housing assistance. Supportive-service expectations will instead reflect each participant's assessed needs, goals, abilities, and circumstances.

Access to Services and Community Coordination

NY-513 supports access to treatment through qualified community providers and encourages on-site, mobile, and community-based service delivery when appropriate. The CoC will continue strengthening coordination among housing providers, behavioral health and substance use disorder treatment providers, healthcare organizations, county Departments of Social Services, public health agencies, justice-system partners, employment and vocational providers, peer and recovery organizations, and other community partners.

Recovery and Self-Sufficiency Planning

Recovery and self-sufficiency planning should begin at program enrollment and continue throughout program participation. Projects should assist participants in increasing income through employment and/or benefits, developing independent living skills, addressing health and behavioral health needs, strengthening natural and community supports, and preparing for successful transition to permanent housing appropriate to the participant's needs.

Performance and Accountability

NY-513 will use HMIS, project performance data, System Performance Measures, project monitoring, and the annual CoC competition process to evaluate project performance and promote accountability for housing stability, successful exits, income and employment growth, engagement in supportive services, and other measurable outcomes.

Participant Protections

This statement will be implemented consistent with applicable federal requirements, including reasonable accommodation requirements, due process protections, confidentiality requirements, and protections for survivors of domestic violence, dating violence, sexual assault, and stalking.

Review and Implementation

This statement applies to NY-513 CoC-funded housing projects and will guide CoC planning, project monitoring, and local competition activities. The CoC will review the statement as needed to maintain consistency with HUD requirements and local system priorities.