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: WV-503 - Charleston/Kanawha, Putnam, Boone, Clay Counties CoC

1A-2. Collaborative Applicant Name: Kanawha Valley Collective, Inc.

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Kanawha Valley Collective, Inc.

1B. Coordination and Engagement–Accountable Structure and Participation

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

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- Frequently Asked Questions

1B-1.	Accountable Structure and Participation.	

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

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

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

17.	State Government Staff/Official(s)	No	
18.	State or Local Elected Public Official(s)	Yes	1
19.	Local Jail(s)	No	
20.	Mental Health Service Organization(s)	Yes	2
21.	Mental Illness Advocate(s)	Yes	2
22.	Organization(s) led by and serving people with disabilities	Yes	2
23.	Other homeless subpopulation advocate(s)	Yes	5
24.	Other nonprofit homeless assistance provider(s)	Yes	10
25.	Other social service provider(s)	Yes	5
26.	Public Housing Agencies	Yes	1
27.	Recovery Housing or Sober Living Provider(s)	Yes	2
28.	School Administrators/Homeless Liaison(s)	Yes	2
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	3
33.	Universities	Yes	1
34.	Veteran Serving Organization(s)	Yes	3
35.	Agencies Serving Survivors of Human Trafficking	Yes	3
36.	Victim Service Provider(s)	Yes	3
37.	Domestic Violence Advocate(s)	Yes	2
38.	Other Victim Service Organization(s)	No	
39.	State Domestic Violence Coalition	Yes	3
40.	State Sexual Assault Coalition	No	
41.	Youth Advocate(s)	Yes	2
42.	Youth Homeless Organization(s)	Yes	1
43.	Youth Service Provider(s)	Yes	1
44.	Other Homeless Assistance Provider(s)	Yes	8
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	2
	Other: (limit 50 characters)		
46.			
47.			

1B-2.	Open Invitation for New Members.	

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

(limit 2,500 characters)

KVC actively seeks new members through personal invitations and broad community outreach. Members invite individuals and agencies they connect with through work functions, meetings, and community events.
When an organization is discussed during a CoC meeting and members believe that organization should be represented at the table, KVC follows up with targeted engagement. Meeting information is also shared through social media and the United Way Community Calendar.
Throughout the year, KVC hosts community outreach events that create opportunities to connect with new individuals and agencies and invite them to participate in the CoC.
Outreach efforts include flyers and postings at local and member agencies, conversations during community meetings, and communication at events such as the WV Housing Conference, Point-in-Time Count media coverage, and local civic group presentations.
KVC also uses Facebook, its website, Twitter, and other platforms to reach individuals, organizations, and community groups.
The CoC makes a specific effort to include people who are currently experiencing homelessness as well as people with lived experience of homelessness.
To support this outreach, KVC develops flyers listing upcoming steering committee and general membership meetings. These flyers are placed at social service agencies and other locations frequently visited by individuals who are experiencing or have experienced homelessness.
Organizations that serve culturally specific communities also receive direct invitations from KVC to encourage broader and more equitable representation.
The CoC Steering Committee reviews representation each month to help ensure that participation reflects the needs and diversity of the region.
KVC continues to create opportunities for organizations not previously involved to engage in the CoC's work and help address equity across the region.

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

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

(limit 2,500 characters)

KVC uses year-round outreach and engagement strategies to gather input from organizations and community members committed to preventing and ending homelessness. Monthly KVC meetings are open to the public and include time for attendees to offer feedback, ask questions, and raise concerns. KVC intentionally seeks participation from people with lived experience, housing and homeless service providers, food and meal providers, health and behavioral health providers, local and state government, faith-based organizations, law enforcement, employment agencies, business owners, neighborhood groups, and other community members.
KVC works to ensure that CoC committees and the Steering Committee reflect the community they serve. Members share information through community meetings and invite new agencies and individuals to become involved. When homelessness-related concerns arise, they are referred to KVC for guidance and connection to the appropriate partners.
Input is gathered through public KVC and CoC meetings, neighborhood meetings, trainings, public events, the KVC website, email lists, webinars, workshops, social media, client interviews, and direct stakeholder engagement. KVC also communicates through website postings, email listservs, social media, and community events to keep partners and community members informed and involved.
KVC also coordinates with local initiatives that rely on community input to shape responses. For example, Charleston's CARE team uses listening sessions, stakeholder meetings, overdose data, and best-practice research to strengthen outreach, housing connections, mental health coordination, substance use response, and quality-of-life strategies for people experiencing homelessness or substance use disorder.
Information gathered through outreach is used to identify service gaps, develop strategies, set priorities, and improve coordination across the region. Feedback from meetings, client interviews, workshops, funding forums, and stakeholder discussions is reviewed by KVC leadership and committees. Meeting minutes and documented feedback help guide Steering Committee recommendations, committee assignments, and next steps, which are shared with the full membership.
This community input has led to concrete changes, including storage options for people experiencing homelessness, new shower and laundry services after previous services closed, funding for a supportive services team, and low-barrier cold weather shelter options.

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

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

(limit 2,500 characters)

Kanawha Valley Collective (KVC), the Collaborative Applicant, notified the public that the local competition was open and accepting project applications, including applications from organizations that do not currently receive CoC funding.
This notice was shared on June 17, 2026, through a public posting on KVC's website and a listserv email announcement.
The announcement specifically invited non-CoC-funded organizations, community stakeholders, and the public to participate in a detailed discussion about new CoC funding opportunities available that year.
That discussion was held by webinar on June 24, 2026, and included time for questions and answers.
The webinar and Q&A were recorded so agencies and members of the public could refer back to the information throughout the application process.
KVC also made clear in its communications that proposals had to be submitted by email using the Intent to Apply form posted on the KVC website.
The June 17, 2026 workshop explained the application process, including eligibility requirements, and helped ensure that all interested parties understood how to submit proposals.
The CoC also informed the public how it would determine which project applications would be submitted to HUD.
This included information about how applications would be scored, the minimum requirements for consideration, threshold requirements, and prioritized subpopulations.
The Written Process was posted publicly on the CoC website, shared through the membership listserv, and explained during the new project webinar and membership meetings.
During these communications, KVC reviewed the local competition priorities and the Prioritization Process so applicants understood how projects would be evaluated.
The CoC uses a locally developed and approved Prioritization Process to decide whether projects will be submitted to HUD for funding.
New projects are scored based on factors such as local community need, HUD best practices, agency experience, equitable outcomes, fiscal capacity, and related considerations.
The scoring tool also makes clear that additional points are awarded to agencies that do not currently receive CoC funding.
After projects are reviewed and ranked, the Steering Committee reviews the Priority Listing and gives final approval for all new projects submitted through the local competition.

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

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

(limit 2,500 characters)

KVC will connect new TH and SSO projects with existing PSH and RRH programs to create a stronger, more flexible system of support for people experiencing homelessness, including individuals with mental health conditions, substance use disorders, and physical disabilities. By expanding the types of interventions available, KVC will be better able to match each household with the right level of support through Centralized Assessment (CA).

During the first three months, KVC will build the infrastructure for TH and SSO projects, finalize policies and workflows, and update CA and By-Name List (BNL) procedures so all project types are included. Providers will receive training on the revised process, and clients will begin accessing TH, SSO, and RRH through updated CA referral pathways. KVC will also formalize partnerships with local FQHCs so clients can connect to physical health care and substance use disorder treatment as part of their housing plans. Through existing PSH renewal projects, KVC will set aside targeted units and resources for older adults and individuals with significant physical disabilities.

By month six, KVC will review how TH, SSO, and RRH are being used to confirm that priority subpopulations are being matched appropriately through the BNL process. Referral pathways and provider workflows will be adjusted as needed based on early performance data. By month nine, RRH, TH, and SSO programs are expected to be operating at full capacity, with continued monitoring of service delivery, housing placements, and housing retention outcomes.

At the end of the year, KVC will complete the annual PIT Count and compare the results with prior years to measure progress in reducing unsheltered homelessness. KVC will also evaluate Centralized Assessment matching, program use, and outcomes for key subpopulations. These findings will help refine intervention strategies, strengthen provider coordination, and guide future CoC planning. Overall, this integrated approach will expand system capacity, improve access to services, and increase successful housing placements for people with high needs.

1B-5a	Confirmation of Plan Coverage.

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

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

1C. Coordination and Engagement

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- Frequently Asked Questions

1C-1.	**Treatment and Recovery Services—On-site Substance Use Treatment Availability.**	
	You must upload the List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment attachment to the 4A. Attachments Screen.	
	What percent of your TH/RRH/PSH projects have substance use treatment available on site?	62%

If you are a rural CoC, describe what substance use treatment is available in your CoC and how people you serve access those services.

(limit 2,500 characters)

Not applicable

1C-1a. Treatment and Recovery Services—Outpatient Treatment for Mental Health and Substance Use Disorders.

Describe how your CoC partners with, or has projects that provide, outpatient treatment for mental health and substance use disorders with a range of appropriate levels of care, psychosocial interventions, medication management, suicide prevention, and recovery supports.

(limit 2,500 characters)

The KVC has strong partnerships with community behavioral health providers, including local Quick Response Teams, Federally Qualified Health Centers (Cabin Creek Health System & Family Care), licensed outpatient treatment centers, and local CMHCs (Prestera Center). These partnerships allow people experiencing homelessness to access a full range of outpatient mental health and substance use disorder (SUD) services. Partners provide various levels of care, including outpatient therapy, intensive outpatient programs (IOPs), medication management, MAT services, crisis intervention, and continuous recovery support. All COC projects—TH, RRH, PSH, and SSO—use standardized screening tools and warm handoff referral procedures to connect clients to the appropriate care level. Through Coordinated Entry, providers assess mental health and SUD needs and refer clients to FQHCs and community behavioral health services. These organizations offer evidence-based psychosocial interventions such as individual and group counseling, cognitive behavioral therapy, trauma-informed care, and peer recovery support. Medication management is available through psychiatric providers and FQHC prescribers, with options like buprenorphine and narcan. Suicide prevention services include crisis lines, mobile crisis teams, and safety planning by licensed clinicians. COC housing stabilization programs also incorporate behavioral health treatment. Case managers collaborate with treatment providers (with client consent), assist clients in attending appointments, and encourage meeting treatment goals. Peer recovery coaches support clients navigating the treatment system, starting recovery, and accessing community-based supports like NA/AA, SMART Recovery, and wellness groups.

Providers also offer relapse prevention planning, crisis stabilization, and specialized services for people with co-occurring disorders or serious mental illness. These partnerships ensure all project participants have access to a full range of outpatient treatment services that support recovery, reduce crises, and improve long-term housing stability. The CoC ensures clients access the right level of care, treatment, and medication management.

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)

KVC coordinates with behavioral health providers, FQHCs, medical systems, and recovery organizations to connect people experiencing homelessness to health, behavioral health, SUD treatment, crisis response, inpatient care, and peer recovery supports. Across TH, RRH, PSH, and SSO projects, providers use standardized screening, documented referral pathways, and warm handoffs to connect participants to services that support housing stability.
Partners include Prestera, Valley, HealthRight, Cabin Creek, Family Care, and Vandalia Health, which provide outpatient behavioral health care, physical health care, psychiatric services, medication-assisted treatment, mobile outreach, and referrals for additional treatment needs. When a higher level of care is needed, the CoC connects participants to inpatient or residential partners such as Harmony Ridge, Clean & Clear, Highland Hospital, and Union Mission.
The CoC also links participants to Peer Recovery Support Specialists through certified peer recovery programs, SUD providers, and recovery centers. Peer specialists help participants navigate treatment, keep appointments, build recovery capital, plan for relapse prevention, access harm-reduction education, and connect to peer-led groups such as NA/AA and SMART Recovery. RRH and TH providers use peer support for early stabilization, while PSH providers partner with recovery organizations for onsite groups, wellness activities, and individualized coaching.

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 uses a standardized, systemwide process to identify individuals experiencing Serious Mental Illness (SMI) and ensure rapid connection to intensive behavioral health services. All access points—including street outreach, emergency shelters, drop-in centers, and Coordinated Entry—screen for indicators of SMI using validated tools, behavioral observations, and client self-disclosure. When individuals disclose mental health concerns, staff ask about treatment history and preferred providers, and make referrals to the treatment option of their choice whenever possible.

The CoC maintains strong partnerships with Prestera Center, HealthRight, FamilyCare (FQHC), Cabin Creek (FQHC), and other community mental health providers to get access to psychiatric evaluation, medication management, crisis stabilization, and outpatient therapy. Prestera's ACT team provides intensive, multidisciplinary services and works directly with multiple existing PSH programs to stabilize individuals with high-acuity needs. ACT staff conduct assertive outreach in encampments, shelters, and housing sites, ensuring engagement even when individuals are reluctant to seek services independently.

For individuals needing higher levels of care, the CoC has established referral pathways to Highland Hospital and Vandalia/CAMC Behavioral Medicine. Individuals who require inpatient commitment go to Bateman for inpatient psychiatric services. Providers coordinate discharge planning with housing programs to prevent returns to homelessness and support continuity of care.

The CoC also partners closely with the City of Charleston's Mental Health Coordinator, who provides quick assistance for individuals experiencing acute psychiatric symptoms and makes quick referrals to long-term services. This role strengthens crisis response within encampments, shelters, and public spaces, ensuring individuals with SMI get assessment and linkage to appropriate treatment.

Across TH, RRH, PSH, and SSO projects, case managers integrate behavioral health needs into housing stabilization plans and coordinate care with ACT teams, outpatient providers, and inpatient facilities. Staff support medication compliance, appointment attendance, crisis planning, and ongoing engagement in treatment. Providers participate in case conferencing and share information (with client consent) to ensure cooperation in systems.

1C-1d. Treatment and Recovery Services—Coordination with Providers in Connection with Drug or Other Specialty Courts.

Identify at least one partnership the CoC has with a provider or entity providing services in connection with Drug Courts and other specialty courts serving individuals with mental and substance use disorders, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment.

(limit 500 characters)

The COC partners with Kanawha County Drug Court to support participants experiencing homelessness. Drug Court staff refer individuals for housing assessments, crisis stabilization, and navigation to shelter, RRH, and PSH. The COC works with WV PEERS to assist participants with treatment engagement and crisis response. COC staff also help participants obtain birth certificates, IDs, and Social Security cards to remove barriers to housing and stability.

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

(limit 2,500 characters)

The COC maintains active partnerships with agencies involved in Drug Court and inpatient civil-commitment providers to support individuals with serious mental illness and substance use disorders experiencing homelessness. The CoC works closely with Kanawha County Drug Court, which regularly refers participants to the CoC's Centralized Assessment Team for housing assessments, crisis stabilization, and connection to treatment and recovery supports. Drug Court probation officers and case managers coordinate with CoC outreach staff to ensure participants receive housing navigation, transportation assistance, and warm handoffs to shelter, Rapid Rehousing, and Permanent Supportive Housing.

The CoC partners with WV PEERS, whose peer recovery specialists directly support Drug Court participants. WV PEERS staff accompany individuals to court hearings, assist with treatment engagement, respond to crises, and collaborate with CoC outreach teams when participants are homeless or at risk. COC staff also help participants obtain essential documents like birth certificates, state IDs, and Social Security cards, removing major barriers to housing, employment, and benefits enrollment.

WV PEERS operates the COSSUP (Comprehensive Opioid, Stimulant, and Substance Use Program), which engages justice-involved individuals through peer-recovery support and diverts them to treatment rather than incarceration. COSSUP assists individuals pre- or post-adjudication to get treatment and supports them during parole with comprehensive transitional plans. Services include case management, linkage to court-ordered treatment, securing post-incarceration housing, employment assistance, connection to social services, and prevention strategies. These peer interventions create a comprehensive care plan that reduces recidivism and supports successful community reintegration.

Although HUD encourages coordination with Assisted Outpatient Treatment (AOT) programs, no AOT programs currently operate within the COC geographic area. In the absence of AOT, the COC relies on strong partnerships with Drug Court, peer-recovery organizations, and inpatient psychiatric providers to ensure individuals with serious mental illness receive coordinated support

1C-1e. Treatment and Recovery Services—Partnership with Local Crisis System of Care.

Identify at least one partnership the CoC has with the local crisis system of care including 988 and crisis contact centers, mobile crisis and outreach services, and crisis stabilization services.

(limit 500 characters)

The CoC partners with the CARES team for crisis intervention. During serious mental health crises, providers contact the CARE1 team, which may involve law enforcement. The CTI-trained CARE1 Team responds to de-escalate, assess on-scene, and link individuals to appropriate services. CARE1 provides trauma-informed intervention and connects people to Prestera, FQHC partners, or inpatient stabilization.

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.	84

1C-1g.	Treatment and Recovery Services—24/7 Access to Detox, Residential, or Inpatient Treatment.	

Is there 24/7 access to detox, residential, and inpatient behavioral health treatment within the geographic area of your CoC?	Yes

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

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

(limit 500 characters)

The COC partners with Prestera Center, the region’s CMHC and behavioral health provider. Prestera offers psychiatric care, outpatient treatment, medication management, Mobile Crisis, CRU stabilization, ACT services, and care coordination for people experiencing homelessness. Its ACT team works directly with PSH programs to support individuals with Serious Mental Illness and ensure continuity of care.

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

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

(limit 500 characters)

Union Mission operates a sober program, and they have applied for TH funding this NOFO. Religious Coalition for Community Renewal has operated a sober living that started receiving HUD funding in 1989, pre-dating COC funding. They are seeking funding for different, additional transitional housing in this NOFO

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

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

(limit 2,500 characters)

The CoC coordinates closely to facilitate warm hand-offs to stable housing providers and prevent entry into homelessness. It has ongoing partnerships with Cabin Creek Health Systems and Family Care, our FQHCs which offer outpatient behavioral health treatment, psychiatric care, medication-assisted treatment, primary care, and recovery-oriented services. If these providers identify patients who are unstably housed or at risk of becoming homeless, they contact the CoC directly to make a warm handoff into the Coordinated Entry system. The staff then carry out diversion, problem-solving, and housing assessments, working with the FQHC care teams to stabilize the household through continued treatment, medication management, and recovery support.

The CoC collaborates closely with the CARE Team, CARE1, and the Charleston Police Department in order to prevent homelessness among people who are come across during crisis calls, as part of street outreach or in the case of behavioral health emergencies. If CARE1 or the CPD come across someone who is unsheltered or who is at immediate risk, they inform the CoC so that the staff can respond promptly and get the individual linked to shelter, RRH, or PSH. In the case of people going through behavioral health crises, the CoC works with Prestera Center's crisis services, Cabin Creek's psychiatric team, and other treatment providers to make sure that the person receives stabilization and recovery support and does not end up becoming homeless.

United Way and West Virginia 2–1–1 also act as further early-intervention partners. If callers indicate that they are at risk of being evicted, that they are victims of domestic violence, that they have unmet behavioural health needs, or that they have concerns about substance use, the 2–1–1 operators apply common screening tools and follow warm-handoff procedures in order to link them directly with the CoC. Meanwhile, United Way staff frequently work together with the CoC on cases that are of high risk, making sure that households get stabilization help, referrals for treatment, and recovery support before they end up in a shelter.

With these coordinated partnerships—covering healthcare, crisis response, treatment providers, recovery services, and community supports—the CoC makes it possible to achieve early intervention, ensures smooth handovers, and provides seamless transitions so that people remain engaged in care and do not end up unnecessarily becoming homeless.

1C-2.	Supportive Services Investment.	

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	$1,552,535
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.	$775,829
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	50%
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.	$363,759
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).	73%

1C-3.	Participation Requirements for Supportive Services.
	You must upload the Language from Project Supportive Service Agreements attachment to the 4A. Attachments Screen.

What percent of your housing projects (TH, PH-PSH, PH-RRH, and Joint projects) require program participants to take part in supportive services (e.g. case management, employment training, substance use disorder treatment) in line with 24 CFR 578.75(h)?	100.00%

1C-4. Consulting with ESG Recipients.

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

(limit 2,500 characters)

The COC maintains ongoing, structured consultation with ESG recipients throughout the planning and allocation of ESG funds. ESG-funded agencies—including YWCA Sojourners and KVC Equinox for Emergency Shelter, Daymark for Children's Emergency Shelter, and YWCA Sojourners, Covenant House, Resolve Family Abuse Program and Religious Coalition for Community Renewal (RCCR) for Rapid Rehousing (RRH)—participate actively in the Funded Programs Committee, Centralized Assessment workgroups, and system performance reviews. Their input directly informs funding priorities, written standards, shelter operations, RRH design, and annual updates to crisis response.

ESG recipients provide feedback on emergency shelter capacity, youth and children's shelter needs, RRH caseloads, outreach gaps, and data quality. The CoC incorporates this information into annual ESG allocation recommendations and performance expectations. The CoC also consults with ESG administrators during Consolidated Plan development, monitoring, and reallocation processes to ensure ESG resources align with CoC system goals and community-identified needs.

This ongoing collaboration makes sure ESG funds are strategically targeted, coordinated with CoC priorities, and responsive to local needs year-round.

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

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

(limit 2,500 characters)

The COC maintains strong, structured coordination with all emergency shelter providers to ensure individuals and families experiencing homelessness are quickly connected to COC assistance. ESG-funded shelters—including YWCA Sojourners, KVC Equinox, and Daymark Children's Shelter—work closely with the COC through the Funded Programs Committee, Centralized Assessment, and weekly case conferencing to identify needs, streamline referrals, and create consistent access to housing resources.

Shelter staff complete initial housing assessments using the COC's Centralized Assessment process, which standardizes how households are evaluated and referred to RRH, PSH, and other housing interventions. These assessments feed directly into the COC's housing queue, naking sure every household is visible to the system and prioritized appropriately.

Weekly case conferencing brings together shelter providers, RRH programs (YWCA Sojourners, Covenant House, RCCR), and PSH partners to review active cases, resolve barriers, coordinate services, and expedite movement from shelter to permanent housing. This routine coordination creates warm handoffs, shared problem-solving, and consistent follow-up for households with complex needs.

Shelters also collaborate with the COC to connect individuals to supports, including behavioral health services, crisis response, domestic violence advocacy, youth services, and trauma-informed care through partners such as Prestera Mobile Crisis, CARE1, REACH, and SANE at CAMC/Vandalia Health.

Through case conferencing, shared assessments, and ongoing communication, the COC makes sure that individuals and families entering shelter are quickly connected to the full range of COC housing resources, reducing the length of time homeless and improving long-term stability.

1C-5. Data Sharing to Inform the Homelessness Response System.

Describe how your CoC has or will share PIT, HIC, HMIS, and System Performance data with state and local government as permitted by law in order to inform the homelessness response system.

(limit 2,500 characters)

The COC has established a comprehensive process for sharing PIT, HIC, HMIS, and System Performance data with state and local government partners, as permitted by law, to strengthen coordination and guide policy, funding, and strategic planning. Each year, the CoC provides full PIT and HIC results to the WV Dept of Human Services (DoHS), state ESG administrators, local governments, and county planning bodies, making sure they have accurate information on homelessness trends, demographic shifts, shelter utilization, and housing inventory changes. State and local partners use these data sets to shape Consolidated Plans, ESG allocations, behavioral health planning, and community development priorities.

The COC also shares aggregate HMIS data with the City of Charleston, Kanawha County, and other local jurisdictions to support decision-making related to emergency shelter operations, outreach deployment, youth homelessness, and housing investments. This includes inflow/outflow trends, length of time homeless, utilization patterns, demographic breakdowns, and returns to homelessness. All shared HMIS data follow strict privacy and security standards, making sure only de-identified or aggregate information is released unless otherwise authorized.

System Performance Measures (SPMs) are reviewed jointly with state and local partners to evaluate progress toward reducing homelessness, improving housing stability, and strengthening the crisis response system. The COC presents SPMs during Funded Programs Committee meetings, Centralized Assessment workgroups, and community briefings, allowing government partners to assess system strengths, identify gaps, and match resources with needs.

The COC also collaborates with state agencies and local governments during the development of the Consolidated Plan, providing PIT, HIC, HMIS, and SPM data to ensure ESG and other federal resources are targeted effectively. Data are shared during monitoring visits, funding consultations, and cross-system coordination meetings with behavioral health, child welfare, youth services, and criminal justice partners.

Through these practices, the COC makes certain that state and local governments have timely, accurate, and actionable data to support policy decisions, strengthen coordination, and improve the overall 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)

The CoC utilizes multiple data sources beyond HMIS to improve care coordination and identify households with the highest needs. Through collaboration with CAMC/Vandalia Health, the CoC reviews de-identified information on frequent emergency room utilizers and individuals with long-term hospital admissions who lack a safe discharge plan. This partnership helps identify people cycling between homelessness and acute medical crises and prioritize them for RRH, PSH, and intensive case management. Hospital social workers attend KVC Membership meetings, strengthening coordination between hospital discharge planning, shelter providers, and CoC housing programs. Kanawha County Sheriff's Office also attends KVC Membership meetings, supporting cross-system communication and early identification of individuals at risk of homelessness.

The CoC integrates behavioral health utilization data, crisis stabilization admissions, and electronic health record information from Prestera, CARE1, and other clinical partners to identify individuals with chronic health conditions, co-occurring disorders, or repeated detox admissions. Prestera Care Coordinators participate in By-Name List Case Conferencing, ensuring individuals with significant behavioral health needs receive coordinated support across housing, treatment, and crisis-response systems.

Admission, discharge, and transfer (ADT) data from hospitals and crisis units are used to prevent discharges into homelessness. Providers alert the CoC when individuals experiencing homelessness are admitted or nearing discharge, allowing the system to coordinate shelter access, RRH enrollment, transportation, and immediate housing placement.

The CoC also collaborates with local law enforcement, corrections, and reentry programs to review jail booking and release data. These partnerships help identify individuals at risk of homelessness upon release and coordinate shelter access, RRH enrollment, and behavioral health linkage.

By combining HMIS with hospital, behavioral health, crisis stabilization, ADT, and justice-system data—and embedding partners directly into CoC coordination meetings—the CoC delivers more effective, targeted, and integrated care.

1C-6. Employment and Workforce Development Partnership.

Identify at least one partnership the CoC has with employment and workforce development programs and organizations such as the Local Workforce Development Board, State Workforce Agency, American Job Center (also known as One-Stop Career Centers), registered apprenticeship program, community and technical college, union training program, adult education provider, or State Vocational Rehabilitation agency.

(limit 2,500 characters)

The CoC partners with Goodwill's job training and employment programs, which provide skills development, job readiness workshops, computer literacy training, and direct connections to employers. Goodwill is the parent agency to Peak Living Services, strengthening coordination between employment supports and housing stabilization services. Goodwill staff work closely with CoC providers to support participants who need foundational employment skills or transitional work experience.

The CoC also collaborates with Job Corps, a federally funded residential training program that provides young adults with vocational training, high-school completion pathways, supportive services, and job placement assistance. Youth providers and RRH case managers refer eligible participants to Job Corps to access structured training and career development opportunities that lead to stable employment and long-term economic independence.

The CoC maintains a strong partnership with the American Job Center (OneStop Career Center) in Kanawha County, where participants can access resume development, job search assistance, career counseling, and referrals to training and certification programs. Shelter providers and RRH case managers routinely refer clients to the American Job Center, and staff coordinates with COC programs to support shared participants in obtaining employment.

Finally, the COC partners with BridgeValley Community & Technical College, which offers short-term credential programs, workforce certificates, and adult education opportunities. CoC providers work with BridgeValley's workforce staff to enroll participants in training aligned with high-demand fields such as health care, IT, manufacturing, and skilled trades, helping clients build long-term career pathways.

Through these collaborations, the COC ensures individuals experiencing homelessness have access to workforce resources that support employment, skill-building, and long-term housing stability.

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

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

(limit 2,500 characters)

The COC's street outreach projects work closely with first responders, law enforcement, and crisis-response partners to increase positive interactions with individuals experiencing unsheltered homelessness and strengthen engagement with housing services. Outreach teams conduct daily engagement in encampments, wooded areas, abandoned structures, riverfront locations, and other sites identified through 911 calls, first responder referrals, and community reports. Staff use trauma-informed, harm-reduction approaches to build trust, provide basic needs, and connect individuals to shelter, RRH, PSH, and behavioral health services.

Street outreach teams regularly coordinate with local police, EMS, fire departments, and the Kanawha County Sheriff's Office, all participating in KVC Membership meetings to share information and identify individuals needing immediate outreach or housing intervention. Law enforcement partners commonly request outreach follow-up instead of enforcement, reducing citations and arrests and promoting voluntary engagement with CoC services.

The CoC's co-response efforts include collaboration with CARE1, the region's crisis intervention team. When first responders encounter individuals in behavioral health crises, CARE1 and outreach staff respond together to de-escalate situations, conduct on-scene assessments, and connect individuals to crisis stabilization, medical care, or housing resources. This approach makes sure individuals with complex needs receive supportive assistance instead of enforcement-based responses.

Street outreach teams also work with hospital social workers and Prestera Care Coordinators, who participate in KVC Membership and By-Name List Case Conferencing meetings. This allows staff to identify individuals with repeated emergency service use or crisis encounters and ensure connection to housing programs and long-term supports.

Through these efforts, the COC increases positive interactions between unsheltered individuals and first responders, reduces emergency service utilization, and strengthens pathways to permanent housing 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)

The CoC and its recipients actively support family and support-network reunification for individuals experiencing homelessness or living in CoC-funded housing. Case managers assess each participant's natural supports during intake and ongoing case planning, identifying family members or trusted individuals who can provide safe, stable housing or long-term support. When reunification is appropriate and desired, providers help facilitate communication, mediate conflicts, and coordinate reconnection with family or supportive networks.

Providers confirm that reunification is voluntary and stable, and coordinate with service providers in the destination community to ensure continuity of care, access to benefits, and linkage to local resources. The CoC also benefits from the City of Charleston's Family Reunification program, which helps individuals reconnect with family or natural supports when safe and appropriate. The program provides transportation assistance and coordination to reunite individuals with relatives who can offer stable housing and support. CoC street outreach teams and shelter staff frequently collaborate with the City to identify individuals who would benefit from reunification and ensure the process is safe, voluntary, and supported.

For participants in RRH or PSH, case managers incorporate reunification goals into individualized housing plans when appropriate, helping individuals rebuild relationships, strengthen natural supports, and reduce isolation. Providers also assist with obtaining identification, vital documents, and communication tools to help participants reconnect with family members. The Centralized Assessment Team supports reunification for unsheltered individuals by contacting family members, arranging safe transportation, and coordinating with crisis-response partners when reunification can prevent further harm or emergency service use.

1C-9	**Partnering with Public Housing Agencies—Agreement to Enable Transition to HUD Assisted Housing.**		
	Does your CoC have an agreement with at least one public housing agency to enable participants to transition from Transitional Housing, Rapid Re-Housing, and Permanent Supportive Housing to HUD assisted housing?	Yes	

1C-10. Protecting Public Safety—Cooperation with Law Enforcement.

You must upload the Evidence of Coordination and Non-Interference with Local Efforts to Advance Protecting Public Safety attachment to the 4A. Attachments Screen.

Describe how your CoC cooperates and does not interfere with or impede local efforts to advance the objectives below, and assists first responders in providing services to homeless individuals.

(limit 2,500 characters)

The CoC actively cooperates with local public-safety agencies and does not interfere with the work of law enforcement, EMS, fire departments, CARE1, or crisis-response teams. The CoC's Centralized Assessment Team maintains daily communication with Charleston Police Department (CPD), EMS, the Kanawha-Charleston Health Department, and Public Works to ensure outreach, assessment, and service connection complement—not obstruct—public-safety operations. When first responders encounter individuals experiencing homelessness, the CoC supports their efforts by responding on-scene, conducting assessments, offering shelter and housing referrals, and coordinating transportation or reunification when appropriate. The CoC participates in encampment operations led by the City of Charleston, ensuring service engagement occurs alongside sanitation and safety activities without delaying or preventing law-enforcement actions. The CoC also respects and supports enforcement of local laws, including the Charleston Encampment Ordinance, the Charleston Trespassing Ordinance, and state public-camping statutes, and does not interfere when first responders determine enforcement is necessary for public safety.

The CoC assists first responders by providing trauma-informed engagement, diversion, crisis stabilization, and warm handoffs to shelter, treatment, and housing programs. CARE1 and EMS notify the Centralized Assessment Team of overdoses, behavioral-health crises, or high-risk encounters, allowing the CoC to follow up quickly with outreach, case management, and housing navigation. The CoC maintains a strict commitment to ensuring individuals comply with legal requirements and will not allow participants to violate restrictions or place others at risk. When staff identify situations that threaten safety, they immediately notify authorities to protect vulnerable individuals and uphold public-safety standards.

Across all activities, the CoC's role is to support—not obstruct—first responders. The CoC enhances public-safety efforts by offering housing-focused solutions, reducing repeated emergency-service utilization, and ensuring individuals contacted by law enforcement or EMS are quickly connected to shelter, treatment, and long-term housing pathways.

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

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

(limit 2,500 characters)

The CoC operates within several local and state policies that both support and hinder its ability to quickly clear tents and encampments on public property while connecting individuals to services. The City of Charleston's Encampment Ordinance establishes formal sanitation and removal procedures, including posted notice—typically 72 hours—coordinated operations led by Public Works, CPD, and the Kanawha-Charleston Health Department, and due-process property storage. These notice periods allow the CoC's Centralized Assessment Team to conduct outreach, diversion, reunification, and shelter or housing placement before tents are removed. The statewide public camping law (HB 5319) also requires officers to inform individuals of available shelter options, creating consistent opportunities for referral to CoC services.

Several policies hinder the CoC's efforts. The new Charleston Trespassing Ordinance expands enforcement authority when individuals remain on public property after being asked to leave, allowing warnings, citations, or arrests for failure to vacate parks, sidewalks, rights-of-way, and other restricted areas. This can accelerate encampment clearances before outreach can complete assessments or offer shelter or housing, and may increase criminal-legal barriers for individuals experiencing homelessness. HB 5319 further creates escalating fines and potential jail time for camping on public property, with each day counted as a new violation even when shelter is unavailable, pushing individuals into hiding and reducing engagement. Additional obstruction and sit-lie rules can result in displacement without service connection.

To leverage supportive policies, the CoC works with CPD, Public Works, EMS, and Kanawha County Health Department to ensure that any trespass warning or encampment notice triggers immediate notification to the Centralized Assessment Team, allowing rapid deployment of outreach and shelter or housing referrals. The CoC uses notice periods to conduct on-site assessments and coordinate transportation through the City's Family Reunification Program when appropriate. To mitigate restrictive policies, the CoC collaborates with law enforcement to prioritize non-enforcement responses, provides trauma-informed training to first responders, and documents all encampment operations through HMIS and the By-Name List to advocate for expanded low-barrier shelter and sanctioned alternatives when mitigation is not possible.

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)

While the CoC continues to have an unsheltered population, encampments have become increasingly rare across the geographic area. Individuals experiencing unsheltered homelessness are now far more transient, often staying within a general area but not sleeping in the same location each night. This mobility results in brief, temporary sleeping spots rather than established encampments, and the sight of tents is now uncommon. Most unsheltered individuals move frequently due to weather, safety concerns, enforcement activity, or personal preference, which prevents the formation of long-standing or structured encampments.

The CoC previously saw larger encampments along riverfronts, wooded areas, and underpasses, but coordinated outreach and structured multi-agency operations have significantly reduced these sites. Today, outreach teams primarily encounter individuals who are dispersed and mobile rather than clustered in fixed locations. Encampments that do appear are typically small, short-term, and quickly resolved through outreach, engagement, and service connection.

Coordinated outreach partners—including WV PEERS, KVC, The SHOP, Covenant House, RCCR, Vandalia Health, and the CARES Team—monitor known areas multiple times per week. The CARES Team provides crisis response, de-escalation, and linkage to behavioral-health services, helping stabilize individuals who might otherwise remain unsheltered. Together, these partners offer basic needs support, crisis stabilization, and pathways to shelter or housing.

Overall, tents and fixed encampments are now sporadic rather than a consistent feature of the local landscape, reflecting both increased mobility among the unsheltered population and the CoC’s ongoing efforts to reduce encampment presence through coordinated outreach and crisis-response partnerships.

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)

State naloxone initiatives and Good Samaritan protections also support rapid response to overdoses and encourage individuals to seek help without fear of prosecution. Locally, Charleston's syringe ordinance imposes strict one-for-one exchange and ID requirements, limiting low-barrier access to sterile supplies & pushing some individuals away from regulated services. Proposed statewide legislation to repeal the syringe services statute would make syringe programs unlawful, leaving only non-syringe harm-reduction services available & reducing opportunities for safe engagement. Criminal penalties for possession, paraphernalia, and public drug use further complicate the CoC's efforts by increasing justice involvement & creating barriers to housing and treatment.
The COC participates in the annual Save-A-Life Day, this year held on September 24th. At least 6 KVC sites were part of the event where naloxone and naloxone education are offered. Additionally, treatment options are discussed, and referrals facilitated.
These policies help the CoC when they require harm-reduction programs to provide or refer to treatment, behavioral health services, and overdose prevention, and when naloxone and Good Samaritan laws make it easier for outreach teams, CARE1, & first responders to intervene quickly. They hinder the CoC when restrictive syringe rules or potential statewide bans reduce access to sterile supplies, increase unsafe injection practices, & push individuals into hidden spaces, making public use more chaotic and harder to engage.
To leverage beneficial policies, the CoC aligns closely with licensed harm-reduction and overdose-response initiatives, ensuring individuals encountered using drugs in public are offered naloxone, crisis intervention, and warm handoffs to treatment, MAT, & housing. The Centralized Assessment Team embeds in public-use hotspots, using Good Samaritan protections to support rapid engagement. To mitigate restrictive policies, the CoC works with law enforcement to prioritize deflection to treatment over arrest, provides trauma-informed and harm-reduction training to first responders, and tracks public-use encounters and referrals to advocate for evidence-based harm reduction & expanded treatment access. If syringe services become fully unlawful, the CoC's mitigation options would be limited; in that case, the CoC would focus on crisis response, treatment linkage, and housing pathways while documenting resulting gaps for policymaker

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)

Drug use does occur in public spaces, even when residents do not always see it directly. The CoC estimates that about 80% of people experiencing homelessness who also have a substance use disorder have used drugs in public places, including vehicles, tents, and public bathrooms. The CoC works alongside the City of Charleston and the State of West Virginia without interfering with their legal efforts to address public drug use. While law enforcement responds through mandatory minimum sentencing for public possession of Schedule I and II substances and through HB 4962 authority to address drug-related public nuisances, CoC services provide another important response: immediate support, stabilization, and safer options for people who might otherwise remain in open-air drug environments.

The local drug supply also includes dangerous non-opioid contaminants, including xylazine, which creates real safety concerns for the community. These substances can cause people to become violent, disoriented, or catatonic, and they may not respond to standard opioid reversal methods. The CoC supports emergency personnel and medical providers as they follow established crisis-response and involuntary-commitment standards to keep the public safe while also helping people who are especially vulnerable. Through this partnership with public-safety and healthcare providers, the CoC helps support long-term regional stability, including a 33% reduction in fatal overdoses from peak levels. When CoC members see drug use in public, whether it involves our clients or other community members, we respond directly and respectfully. We speak with the person, offer help, and connect them to treatment options whenever possible. If someone notifies us about drug use in our service area, we go out to address the situation and offer support.

During localized public-health crises, such as non-fatal overdose spikes on Charleston’s West Side, the CoC responds quickly with municipal first responders. We respect the City’s role in enforcing pedestrian-safety ordinances and clearing hazardous public spaces, while our outreach teams focus on the people most at risk, especially unsheltered women and youth who may be vulnerable to exploitation in open-air drug markets. By connecting people directly to safe emergency shelter beds, the CoC helps make public spaces safer while reducing the chance that vulnerable people are pushed into even greater danger.

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)

According to West Virginia Judiciary — Data Dashboard (Magistrate Court ¿ Special Proceedings ¿ Mental Hygiene), Kanawha County, Calendar Year 2025, Kanawha County continued to experience one of the highest levels of mental-hygiene activity in West Virginia. In 2025, a total of 1,142 mental-hygiene petitions were filed, resulting in 684 petitions granted and 312 individuals committed for involuntary hospitalization. Kanawha consistently represents 11–12% of all statewide mental-hygiene activity, underscoring its role as a major hub for emergency behavioral-health interventions. This volume strains homelessness-response operations, law enforcement, EMS, and hospital emergency departments by increasing demand for psychiatric beds, prolonging ED boarding, and creating repeated contact between individuals in crisis and public-safety agencies.

When individuals who clearly need psychiatric commitment cannot be committed, law enforcement becomes the default behavioral-health system. Officers repeatedly encounter the same people in crisis, transporting them to emergency departments that cannot admit them and releasing them without stabilization. Shelters, outreach teams, and transitional housing programs absorb the fallout, managing acute psychiatric symptoms they are not clinically equipped to treat. Staff face unsafe behavior, repeated evictions, and burnout, reducing the community’s ability to maintain stable housing placements. Community safety declines as untreated individuals experience preventable injuries, victimization, and harm.

The CoC has witnessed two severe examples of these consequences. One individual who staff were unable to get committed was struck by a truck and killed. Another, previously civilly committed and awaiting guardianship, walked into traffic and was hit by a car. She survived but required multiple surgeries, spent months in a nursing home, and is now in her family’s care. These incidents show the real danger when people who likely need involuntary commitment do not receive it

1C-10f. Protecting Public Safety—Share Information in Accordance with SORNA.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to comprehensively share information, including location information, in accordance with the Sex Offender Registry and Notification Act (SORNA) and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

The CoC operates within federal, state, and local frameworks that shape how information—including location information—can be shared in accordance with the Sex Offender Registration and Notification Act (SORNA). West Virginia's sex-offender registry statute requires individuals to register their residential address or location, including when they are homeless, and mandates regular verification through law enforcement. This statewide system provides an authoritative source of registry information that the CoC can access through formal coordination with law enforcement, probation, and parole. Locally, police departments and supervision agencies maintain policies that allow sharing of registry-related information with homeless service providers when necessary for public safety, compliance with court-ordered restrictions, or placement considerations. These policies help the CoC by enabling case managers and the Centralized Assessment Team to confirm registry status, understand proximity restrictions, and avoid housing placements that could inadvertently violate legal requirements.

To leverage beneficial policies, the CoC maintains formal information-sharing agreements with law enforcement, probation, and parole that clearly define when registry information can be accessed and how it can be used for housing and safety planning. The Centralized Assessment Team incorporates registry checks, when appropriate, into Coordinated Entry case conferencing to ensure compliant housing placements and timely address updates. Case managers obtain informed consent whenever possible and explain how registry requirements affect housing options and reporting obligations.

The CoC also maintains a strict commitment to ensuring that individuals on the sex offender registry comply with all legal requirements. The CoC will not allow any participant to violate registry restrictions or place others at risk. Recently, a client disclosed to a service provider that they had been staying in a family member's home where children also lived, a clear violation of their registry conditions. Believing that the children could be in danger, the staff member immediately reported the situation to authorities, resulting in the individual's arrest and incarceration. This incident demonstrates the CoC's responsibility to balance participant support with public safety, and its practice of acting swiftly when registry violations or risks to vulnerable individuals are identified.

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)

KVC provides coordinated Street Outreach across the entire CoC geographic area to find and connect with people living outside. Outreach teams are available seven days a week from 8 a.m. to 9 p.m., giving them time to meet people in the morning, during the day, and in the evening. Teams travel throughout Charleston, South Charleston, Dunbar, St. Albans, Nitro, and unincorporated areas of Kanawha County, as well as rural Clay, Boone, and Putnam Counties. In these areas, homelessness is often hidden, with people staying in wooded areas, along riverbanks, in cars, in abandoned buildings, or in isolated encampments. Teams maintain coverage through regular visits to known hotspots, follow-up in new locations, and ongoing communication with EMS, CARE1, CPD, WV PEERS, sheriff's departments, hospitals, libraries, and community partners who alert outreach when new unsheltered sites are identified.

Every outreach contact, assessment, and housing placement is documented in HMIS and coordinated through the Centralized Assessment Team so people receive consistent follow-up and housing navigation across the region. Staff take time to understand each person's needs and help address them directly. They explain and offer support with SPDAT and HUD applications, bring health care access, HIV testing, and prevention services directly to unsheltered locations, and provide food, clothing, blankets, and hygiene supplies. These supports help reduce barriers for people who may be least likely to seek help on their own and ensure they can receive services outside a traditional office setting. Transportation is also available to help people get to medical providers, behavioral health services, shelters, and other community organizations.

Street Outreach teams also help people connect with substance-use treatment, including MAT providers, detox programs, and recovery supports. When someone wants to relocate safely or reconnect with family, staff can help explore family reunification options. Outreach teams focus on building trust with people living in cars, parks, abandoned buildings, encampments, and other unsheltered places. Through community partnerships, teams can also provide cell phones so people can stay in touch, keep appointments, and continue working with case managers and housing navigators.

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

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

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

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

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

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

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

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

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

(limit 2,500 characters)

The CoC's written policies and procedures require all providers participating in Coordinated Entry, emergency shelter, outreach, and housing programs to inform households with school-aged children and unaccompanied youth of their eligibility for educational services under the McKinney-Vento Homeless Assistance Act. At intake, providers must ask whether children or youth are enrolled in school and immediately provide information on educational rights, including school stability, transportation assistance, immediate enrollment without documentation, and access to special-education and support services.

CoC policy requires each provider to maintain updated contact information for McKinney-Vento liaisons in all local school districts. Providers must notify the appropriate liaison within one business day when a family or youth enters shelter, outreach, or housing programs to ensure the student receives transportation, enrollment support, and other educational services. These notifications are documented in HMIS or the non-HMIS DV system.

McKinney-Vento liaisons actively participate in CoC Membership meetings, strengthening coordination between school districts and homeless-service providers. The WV Department of Education's McKinney-Vento State Coordinator has provided formal training to CoC staff on educational rights, enrollment protections, transportation requirements, and dispute-resolution processes. In turn, CoC staff conduct trainings for school personnel—including counselors, social workers, attendance directors, and administrators—on available homeless-services resources, Coordinated Entry access, referral pathways, and how to identify and support students experiencing homelessness.

The CoC's written standards also require providers to distribute written materials explaining educational rights during intake, outreach contacts, and case-management meetings. Providers must review these rights verbally to ensure understanding and assist with obtaining school records, identification documents, and transportation arrangements when needed.

Through these policies and partnerships, the CoC ensures that families and youth experiencing homelessness are consistently informed of their educational rights and quickly connected to school-based supports that promote stability and academic success.

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

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

(limit 2,500 characters)

The CoC works with WV Department of Human Services Child Protective Services (CPS), foster-care agencies, McKinney-Vento school district liaisons, and youth-serving providers to help young people move from public systems of care into stable housing and support. When a youth faces placement instability, is leaving custody, or is close to aging out, CPS contacts the CoC's Centralized Assessment Team early so assessments, housing plans, and connections to Rapid Rehousing, Transitional Living, and other supports can begin before the situation becomes a crisis.

The CoC also partners with McKinney-Vento liaisons, who are often among the first to know when a student is experiencing homelessness, unstable housing, or the loss of a foster-care placement. Together, they help students stay enrolled, access transportation, and connect with housing programs, case management, and behavioral-health services.

First Presbyterian Hope Center is a new CoC partner, and its Executive Director serves on our board. The Hope Center helps young adults ages 18 to 25 in Kanawha and Clay counties transition from foster or kinship care through caring relationships, case management, mentoring, and support that builds stability, confidence, and independence.
Daymark operates Patchwork and New Connections, which support youth and young adults experiencing homelessness or leaving foster care. New Connections offers GED and Independent Living programs, including supervised on-site apartments and help with education, employment, and daily living skills. The partnership includes KVC meetings, a shared TGKVF grant, and regular communication about referrals and resources.

The CoC also participates in the Foster Youth Initiative Program with Charleston-Kanawha Housing and DoHS. The program provides dedicated housing vouchers and supportive services for youth leaving foster care, including help with applications, benefits, employment, education, life skills, case management, and long-term supports.

The CoC works with CPS to support safe reunification when appropriate, coordinate with kinship caregivers, and connect youth leaving residential care or crisis placements to housing and behavioral-health services. For youth with more complex needs, partners plan safe discharges and warm handoffs to long-term support.

Through these partnerships, the CoC helps young people get support earlier, complete coordinated assessments, and find a clear path to stable housing.

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

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

(limit 2,500 characters)

We do not have a RHY funded provider in our COC

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)

Branches DV RRH primarily serves families with children

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

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

(limit 2,500 characters)

Branches DV RRH provides supportive services designed to help survivors increase income and maintain long-term housing stability. Case managers work one-on-one with participants to identify employment goals, remove barriers to work, and connect them to workforce development programs, job training opportunities, and registered apprenticeship pathways that lead to sustainable wages. Staff assist survivors with job applications, resume building, interview preparation, and accessing short-term financial supports needed to begin employment. When serving adults with children, Branches staff coordinate directly with a dedicated contact at the West Virginia Bureau for Family Assistance (BFA) to ensure families receive timely access to TANF, SNAP, child care assistance, and other income-stabilizing benefits.

Branches staff also maintain close working relationships with Putnam County Adult Education, which offers GED preparation, ACT, ACCUPLACER, TEAS, and ASVAB testing support, along with nationally recognized certifications in Microsoft Office, Customer Service, Work Ethic, QuickBooks, IC3, Resume Writing, FAFSA assistance, and Career Exploration. Putnam County Adult Education also assists survivors in pursuing post-secondary education, including enrollment in college programs or career-technical classes, helping participants build long-term earning potential and access higher-wage employment pathways.

Clients who meet eligibility requirements may also be referred to Good News Mountaineer Garage, which helps families obtain quality, dependable used cars. Access to reliable transportation significantly improves survivors' ability to maintain employment, attend training programs, reach child care, and sustain long-term housing stability.

These income-focused services are paired with housing navigation, safety planning, and flexible financial assistance to ensure survivors can pay rent, stabilize quickly, and remain safely housed.

1C-13b. Collaboration Related to Families with Children—Leveraging Funding from Mainstream Family Service Systems.

Describe how the project(s) identified in 1C-13 leverages funding from mainstream family service systems, such as Temporary Assistance for Needy Families (TANF).

(limit 2,500 characters)

When serving adults with children, Branches DV RRH staff coordinate directly with a contact at the West Virginia Bureau for Family Assistance (BFA) to make sure families receive timely access to TANF, SNAP, child care assistance, and other income-stabilizing benefits. Staff help survivors complete applications, gather required documentation, and navigate eligibility processes so households can quickly secure the financial supports needed to stabilize income and maintain housing. This coordination ensures that families fleeing domestic violence are not delayed in accessing essential benefits that support rent payments, food security, and overall household stability.

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)

Branches DV RRH combines housing assistance with a comprehensive set of family-centered supports to ensure survivors who have children may stabilize rapidly and keep their long-term housing. The case managers work closely with the parents to determine their childcare requirements and link them with childcare subsidies, early-learning programs, and providers who take trauma into account so that the adults can go ahead with employment, education, or healing without any interruption. They also give constant support to parents, including making safety plans for the children, telling them about school transitions, and referring them to parenting programs which improves family stability.

Branches coordinates access to healthcare related to pregnancy and for children, helping families to obtain prenatal care, postpartum support, pediatric care, immunizations, WIC services, and developmental screenings. The staff work closely with FamilyCare, an FQHC that runs a birthing center and offers physical he, behavioral health services, medication-assisted treatment (MAT), and pediatric care, so that survivors and their children can receive comprehensive medical care that is trauma-informed. The staff also help by scheduling appointments, arranging transportation, and linking families with providers who are aware of the issues involved in domestic violence and trauma. If further materials or baby-care support is required, the staff refer families to The Gabriel Project, which provides diapers, formula, clothing, baby equipment, and other essential items.

Education support is completely part of the housing model. The branches work directly with McKinney-Vento liaisons so that children who are experiencing homelessness can get immediate school enrollment, transportation, access to school supplies, and educational stability. Adults who are seeking education are linked with partners such as Putnam County Adult Education to help them with GED preparation, testing support, certifications, and with enrollment in college or career-technical programs.

By bringing together housing assistance, childcare, parenting support, healthcare coordination via FamilyCare, the educational protections provided by the McKinney-Vento Act, and referrals to programmes such as The Gabriel Project, Branches provides fleeing families with support that helps promote their safety, stability and independence.

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)

PEAK Living Services partners with the VA through its Veterans Lifeway Center, a GPD program offering low-demand transitional housing and case management for homeless male Veterans. PEAK coordinates referrals, housing supports, healthcare, benefits, and other VA services. KVC also partners with SSVF providers Logan Pride and Coalfield CAP through CoC and By Name List efforts, and provides daily office space for a VA outreach specialist.

1C-14a	Collaboration with Veteran Serving Organizations.	
	Select 'Yes' or 'No' in the chart below to indicate whether the partnership(s) identified in 1C-14 does the following:	

1.	Refers veterans identified by the CoC to VA or other Veteran Serving Organizations for assistance?	Yes
2.	Coordinates the provision of emergency shelter, supportive services, and housing for veterans?	Yes
3.	Ensures access to a full spectrum of employment and career pathway opportunities?	Yes
4.	Shares data with the Department of Veterans Affairs as appropriate?	Yes
5.	Identifies service gaps for veterans?	Yes
6.	Fills service gaps for veterans?	Yes

1C-15. Collaboration with Organizations who Address the Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.

Identify at least one partnership your CoC has with victim service providers, state domestic violence coalitions, state sexual assault coalitions, anti-trafficking service providers or other organizations who help provide shelter, housing, and services to individuals and families of persons experiencing trauma or a lack of safety related to fleeing or attempting to flee domestic violence, dating violence, sexual assault, and stalking.

(limit 500 characters)

The COC maintains strong partnerships with victim service providers to ensure survivors of domestic violence, sexual assault, and stalking access safe shelter and housing. The WV Coalition Against Domestic Violence's Board President serves on the CoC, and the CoC's Executive Director serves on the Coalition's Board. A licensed DV shelter director was appointed by the Governor to the WV Family Protection Services Board, strengthening alignment with statewide standards.

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)

Union Mission Ministries, PEAK Living Services, and KVC partner with jails, prisons, parole, and specialty courts to support justice-involved individuals. Through Coordinated Entry, By-Name List discussions, and case management, participants are connected to housing, benefits, healthcare, transportation, treatment, workforce programs, and other supports that promote long-term housing stability.

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)

WV HealthRight offers comprehensive medical services for individuals experiencing homelessness with significant health needs. The clinic completes full medical intakes—including physicals, COVID testing, and TB testing—for every person referred to emergency shelter. HealthRight clinicians coordinate closely with RRH and PSH case managers to support treatment adherence, stabilize clients after hospital discharge, and reduce avoidable ER use.

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)

Autumn Lakes Nursing Home has partnered with the CoC for more than 15 years to support individuals experiencing homelessness with high medical needs. The facility provides skilled nursing, medication management, rehabilitation services, and coordinated discharge planning. CoC case managers work with Autumn Lakes staff to stabilize clients and ensure continuity of care during housing placement.

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)

Shanklin Center provides PSH to people experiencing chronic homelessness

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)

Shanklin Center provides onsite behavioral healthcare through a therapist who is available onsite at least once each week. Because Shanklin serves only 11 women, this creates meaningful access to care within a small, specialized program. Although not every resident wants or needs therapy every week, having a regular onsite therapist allows residents to receive support when they are ready to engage. Services include individual and group therapy, supportive counseling, psychoeducation, and assessments to determine whether additional behavioral healthcare is needed. The therapist also coordinates with outside providers so residents can access medication management, psychiatric services, or a higher level of treatment when appropriate.

Vandalia Health also provides onsite physical and behavioral healthcare every other week, giving residents consistent access to psychiatric medication support and primary healthcare while reducing barriers such as transportation and long wait times. Shanklin maintains strong partnerships with Prestera Center and Cabin Creek Health Systems, which allows residents to continue care with their preferred behavioral health provider. These connections give residents multiple treatment options while also ensuring regular onsite access to both physical and behavioral healthcare. Together, these services create a flexible, responsive support system that promotes stability and helps residents maintain their health and housing.

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)

Shanklin Center has policies and procedures in place to assess residents' needs and connect them to outside care when a higher level of support is required. Staff work with a range of community partners to ensure women participating in the PSH project can access the appropriate level of physical, behavioral health, or long-term supportive care.

When a resident needs assisted living, rehabilitation, or another higher level of physical care, Shanklin staff coordinate directly with the resident's healthcare provider. In the past, staff have arranged placements with physical rehabilitation centers and long-term care facilities for residents who needed more intensive support, including short-term care following a stroke or limb amputation. When the placement is expected to last 90 days or less, consistent with HUD PSH requirements, staff help secure the placement, remain in contact with the resident during treatment, provide support as needed, and coordinate the transition back to the program. If a resident needs to move permanently to assisted living or a nursing home, staff follow the same coordination process and discharge the resident from the PSH program once the transfer is complete.

Residents may also need a higher level of behavioral healthcare. In those situations, staff consult with the resident's psychiatrist, therapist, or broader healthcare team to determine the most appropriate next steps. If the resident is not already connected to providers, Shanklin staff help link them to crisis services such as the CARE Team or Prestera Center's Crisis on Call team. These partnerships allow residents to access crisis stabilization, psychiatric evaluation, and intensive outpatient services when needed.

Through these protocols and partnerships, the Shanklin Center supports residents across changing levels of need, whether short-term, long-term, physical, or behavioral. This approach helps ensure residents receive appropriate care while the program remains aligned with HUD PSH requirements.

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)

At the Shanklin Center, moving on from PSH is treated as a personal decision, not just a program step. The Center's formal Move-On Policy gives staff and residents a thoughtful way to talk about whether someone may be ready for unsubsidized or other permanent housing. Each year, staff use the full SPDAT, as required under 24 CFR §578.53, to look at the resident's stability, daily living skills, income and benefits, physical and behavioral health needs, and overall independence. When a resident reaches supportive-service goals or begins thinking about a move, staff sit down with them to talk through their hopes, concerns, and readiness. The SPDAT helps guide whether services should continue, be adjusted, or whether the resident may be ready for the next step. If they are ready, staff help find housing options, complete applications, gather documents, and coordinate with outside providers so the move feels safe and supported. If they are not ready, services continue and staff revisit the conversation through regular case management. This process keeps each transition voluntary, individualized, and grounded in the resident's strengths, stability, and long-term goals.

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

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

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

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

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

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

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

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

	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website–which included: 1. the CoC Application, and 2. Project Priority Listings.	09/28/2026

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

	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/23/2026

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

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

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

1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	09/23/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

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

	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	09/23/2026

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

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

(limit 2,500 characters)

The CoC uses a structured reallocation process to ensure funding is directed toward high-performing, high-need projects. Each year during the local competition, the Ranking Committee evaluates all renewal projects using objective criteria, including system performance measures, HMIS data quality, utilization rates, spending patterns, housing outcomes, and alignment with CoC priorities. Projects that demonstrate persistent underperformance, chronic underspending, low utilization, or misalignment with current system needs are identified as candidates for reallocation. The CoC also considers whether project types remain necessary based on gaps identified through coordinated entry, by-name list trends, and annual needs assessments.

During this year's local competition, the CoC identified several projects that met the threshold for reallocation. Based on performance data, utilization concerns, and system need, the CoC determined that two PSH projects and one RRH project were less needed in their current form. These projects were evaluated against community priorities, including the need for increased Transitional Housing capacity to support individuals with behavioral-health needs, people exiting institutions, and households requiring short-term stabilization before moving to permanent housing.

As a result, the CoC reallocated three projects. Two PSH projects were reallocated to TH, and one RRH project was also reallocated to TH. This allowed the CoC to create new TH projects that better respond to current system gaps and improve movement from unsheltered homelessness, emergency shelter, and crisis stabilization programs into more appropriate housing pathways.

Because these lower-performing or less-needed projects were successfully reallocated, the CoC did not need to reallocate any additional projects this year. The CoC will continue to review project performance and system needs each year to ensure resources are directed to interventions that best support community priorities and improve overall system performance.

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

	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2021 and FY 2026?	No

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

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

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

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

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

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

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

2A-3.	**PIT Count–Methodology Change.**	

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

(limit 2,500 characters)

Not Applicable

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

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

(limit 2,500 characters)

During the evaluation period, the COC used targeted funding and coordinated outreach to reduce encampments and the number of people living in them. Outreach teams regularly visited specific encampment sites identified through 911 calls, partner referrals, and City postings. During these visits, teams completed assessments, discussed diversion options, explored reunification when appropriate, and connected individuals to shelter or housing referrals. Funding also supported coordinated work with the Charleston Police Department, Public Works, EMS, and the Kanawha-Charleston Health Department to address encampments through planned, multi-agency operations focused on voluntary engagement, transportation to shelter, and service connection rather than enforcement. A coalition of partners, including KVC, WV PEERS, The SHOP, Covenant House, the Religious Coalition for Community Renewal, and Vandalia Health, went into encampments together to provide trauma-informed outreach, basic needs support, crisis stabilization connections, and warm handoffs to treatment or shelter. As a result, more individuals accepted shelter or reunification assistance during encampment operations, and fewer people remained in unsheltered locations.

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

1. Enter the estimated number of encampments in the beginning of your evaluation period.	24
2. Enter the reduction in the number of encampments during your evaluation period.	19

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

1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	74
2. Enter the reduction in the number of people in encampments during your evaluation period.	14

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

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

(limit 2,500 characters)

Not applicable

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

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

(limit 2,500 characters)

The CoC's strategy to reduce first-time homelessness focuses on identifying households at risk as early as possible and connecting them quickly to prevention resources. The CoC works closely with the Housing Authority to support tenants who are facing eviction. Depending on the household's need, staff may provide direct assistance or connect families to resources such as 2-1-1, DHHR emergency programs, Dollar Energy, LIEAP, and other utility-assistance programs.
The CoC also uses non-traditional funders and local foundations to provide flexible homeless-prevention assistance, including rent arrears, security deposits, and first month's rent. Households are connected to stabilizing supports such as food assistance, utility payments, transportation help, and other services that help them remain safely housed.
For families with school-age children, McKinney-Vento liaisons help identify early signs of housing instability and make referrals before a housing crisis becomes homelessness. When eviction is imminent or legal support is needed, the CoC connects households to Legal Aid for representation, mediation, and advocacy.
Through coordinated outreach, cross-system partnerships, and targeted financial assistance, the CoC works to prevent shelter entry, stabilize households sooner, and reduce the number of individuals and families experiencing homelessness for the first time.

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

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

(limit 2,500 characters)

The COC strategy to reduce the length of time individuals and families remain homeless focuses on helping households stabilize quickly and move into housing as soon as possible. Case managers explore family reunification when it is safe and appropriate, helping participants reconnect with natural supports that may shorten their time in shelter or unsheltered settings. Staff also help households complete housing applications, gather required documents, and search for units beyond public or subsidized housing so families have more options and fewer delays.
The COC also works to establish or restore income by connecting households to DHHR benefits, SSI/SSDI assistance, employment programs, and workforce development partners. Participants are linked to education and job-readiness resources, including HISET preparation, job training, resume building, and Workforce WV programs, to support long-term housing stability.
Providers use targeted financial assistance, such as deposits, first month's rent, utility support, food resources, and transportation, to remove barriers that can keep households homeless longer. Behavioral health providers, peer-support teams, and other partners help participants stay engaged, attend appointments, and resolve issues that may delay placement. Together, these services help the COC shorten the time households spend homeless and increase successful housing placements.

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?	24.00%

Describe how you calculated the data for this response.

(limit 2,500 characters)

An HMIS report for the period from January 1, 2025, through December 31, 2025, showed that 183 individuals exited TH, RRH, or PSH projects. Of those individuals, 44 exited to permanent housing destinations, including staying with friends or family with permanent tenure, rental housing without an ongoing subsidy, or housing owned by the client without an ongoing subsidy. This represents a 24% positive exit rate.
Projects included in this calculation were Covenant House CoC RRH, Covenant House Rapid Rehousing, Covenant House Housing First, CoC Housing, RCCR RRH, Shanklin Center for Seniors, and Twin Cities.

An HMIS report for the period from January 1, 2025, through December 31, 2025, showed that 875 individuals exited ES, TH, or RRH projects. Of those individuals, 480 had a positive exit. This represents a 54% positive exit rate.
Projects included in this calculation were Covenant House CoC RRH, Covenant House Rapid Rehousing, Covenant House Housing First, CoC Housing, RCCR RRH, Sojourners Shelter, and Equinox Shelter.

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

	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	02/25/2026

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

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

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

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

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

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

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

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

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	157	25	167	86.00%
2. Safe Haven (SH) beds	10	0	10	0.00%
3. Transitional Housing (TH) beds	3	0	3	100.00%
4. Rapid Re-Housing (RRH) beds	45	64	109	100.00%
5. Permanent Supportive Housing (PSH) beds	140	0	78	55.70%
6. Other Permanent Housing (OPH) beds	0	0	0	0.00%

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

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

(limit 2,500 characters)

The CoC continues to strengthen HMIS participation through sustained engagement with key partners. Our local faith-based shelter, which previously showed little interest in HMIS participation, is now receptive to adopting ServicePoint, representing meaningful progress from prior years. We will continue working with them to support full integration. In addition, our PSH beds outside of ServicePoint are limited to HUD-VASH. Although past conversations with the VA have been positive, full HMIS integration has not yet occurred; the CoC will continue pursuing collaboration with the VA to bring these units into ServicePoint.

3A. Policy Initiatives

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

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

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

1.	**Will the proposed activities/projects occur within Opportunity Zone Census Tracts?**	Yes
2.	**Do you expect to use at least 50% of the proposed activities/projects in Opportunity Zones Census Tracts?**	Yes

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

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

4A. Attachments Screen For All Application Questions

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

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

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

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

Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	List of TH/RRH/PS...	09/28/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	1C-1f. List of Co...	09/28/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	Language from Sup...	09/27/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes		
05. 1D-1. Local Competition Scoring Tool	Yes	1D-1 Local Compet...	09/27/2026

06. 1D-2c. Local Competition Selection Results	Yes	1D-2c. Local Comp...	09/28/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	2A-8b. FY 2026 HD...	09/27/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No	3A-1. HUD-2996 Ce...	09/28/2026
09. 3A-2a. Project List for Other Federal Statutes	No		
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No	3A-DP. Your CoC's...	09/27/2026
11. Other	No		

FY 2026 RENEWAL PSH/RRH/TH PROJECT SCORECARD

PART A: PROJECT DESIGN AND ELIGIBILITY- THRESHOLD

Criteria		*Applies to*	*Scorer*	*Submission*
A.1	Project Eligibility	PSH/RRH	KVC Staff	File
A.2	Project Summary	PSH/RRH	KVC Staff	Narrative

PART B: PROJECT PERFORMANCE

Criteria		*Applies to*	*Scorer*	*Submission*	*Total Points Possible*	*Score*
B.1	Positive Exit Destinations	PSH/RRH	Auto	APR Data	5	
B.2	**Returns to Homelessness** (Exits to Homeless Destinations)	PSH/RRH	Auto	APR Data	6	
B.3	**Client Employment Income (Earned Income)**	PSH/RRH	Auto	APR Data	6	
B.4	Non-employment Cash Income	PSH/RRH	Auto	APR Data	4	
B.5	Mainstream Benefits	PSH/RRH	Rank & Review	Narrative	4	
B.6	**Service Participation Requirement**	PSH/RRH	Rank & Review	Narrative	6	
B.7	High Need Population	PSH/RRH	Auto	APR Data	12	
B.8	Utilization Rate	PSH/RRH	Auto	APR & CoC App	5	
B.9	Monitoring	PSH/RRH	KVC Staff	Narrative & KVC Staff	4	
B.10	Grant Spenddown	PSH/RRH	Auto	APR Data	5	
B.11	Promoting Recovery, Agreements and Commitments	Rank & Review	Rank & Review	Narrative	3	
B.12	Promoting Recovery (on-site treatment)	Rank & Review	Rank & Review	Narrative	3	
B.13	Performance Discretionary	PSH/RRH	Rank & Review	Narrative	4	
				Sub-Total	**67**	

PART C: COMMUNITY PRIORITIES

Criteria		*Applies to*	*Scorer*	*Submission*	*Total Points*	
C.1	Lived Experience	PSH/RRH	Rank & Review	Narrative	3	
C.2	Data and HMIS	PSH/RRH	Auto	APR Data	3	
C.3	CE Acceptance	PSH/RRH	Auto	HMIS Data	3	
				Sub-Total	**9**	

PART D: BONUS POINTS

Criteria		*Applies to*	*Scorer*	*Submission*	*Points*	
D	Substance use treatment engagement	PSH/RRH	Rank & Review	Narrative	**3**	

Total Score: 76

Objective Criteria: 66

Objective Rating: 94%

Performance Points: 18

Performance Rating: 26%

FY 2026 RENEWAL PSH/RRH PROJECT APPLICATION

PART A: PROJECT DESIGN AND ELIGIBILITY- THRESHOLD

A.1 Project Eligibility: *Please verify your project's eligibility as a recipient of the CoC grant. Submit the project's draft HUD e-snaps application.* *Attach letters of commitment, contracts, or other formal documents that demonstrate the commitment of at least 25% match. Attach your supportive service agreement. Attach your completed Threshold Assessment Checklist.*	
Required Submissions: *Draft HUD e-snaps Application; HUD Grant Agreement, Attachments.*	***Scoring:*** *n/a*
A.2 Project Summary: *Please summarize the day-to-day operation of your project with details on the type and scale of assistance to be offered (including the funding source or partnership of each).* *[For PSH:] Include the number and configuration of units and describe how they fit the needs of the program participants.* *[For RRH:] Describe how the provision of tenant-based rental assistance will help individuals and families achieve self-sufficiency within 24 months.*	
Required Submission: *Narrative (800-word limit)*	***Scoring:*** *n/a*

PART B: PROJECT PERFORMANCE

System performance benchmarks were obtained by evaluating APRs from July 1, 2025 – June 30, 2026. The benchmarks are included in the middle of the bolded scoring ranges for each of the KPIs below. As the system performs at the respective average, it is expected that individual projects perform in that range as well. Projects that performed above the average are awarded the top score for the respective KPI. Project performance is assessed using APR and HMIS custom reports information for this timeframe, and the most recently submitted APR in Sage for the financial information.

Permanent Supportive Housing (PSH) scoring ranges are marked in black and Rapid Rehousing (RRH) in blue.

B.1 Positive Exit Destinations: *As reported in the APR, the percentage of people who exited the project during the year to a permanent destination (PSH/RRH) or continued to be stably housed (PSH).*		
Data Autoscored: *APR Qs 23c, 5a* **PSH:** (5a8 Number of Stayers + Q23c Total persons exiting to Permanent Situations) / (5a1 Total number of persons served – Q23c Total persons whose destination excluded) **RRH:** Q23c Total persons exiting to Permanent Situations / (Q23c Total –	***Scoring (PSH):*** ***5*** = 95% or more ***4*** = **93 – 94.9%** ***3*** = 90 – 92.9% ***2*** = 87 – 89.9% ***1*** = 84 – 86.9% ***0*** = less than 84% ***5 Points Total***	***Scoring (RRH):*** ***5*** = 82% or more; ***4*** = **79 – 81.9%;** ***3*** = 76 – 78.9%; ***2*** = 72 – 75.9%; ***1*** = 68 – 71.9%; ***0*** = less than 68%; ***5 Points Total***

Q23c Total persons whose destination excluded)		
***B.2* Returns to Homelessness (Exits to Homeless Destinations):** *As reported in the APR, the p*ercentage of people in the project who exited the project during the year to a homeless situation (place not meant for habitation, emergency shelter, including hotel or motel, host homes and safe haven) (measure closest to recidivism).		
Data Autoscored: *APR Q 23* Q23c Subtotal - Homeless Situations / (Q23c Total – Q23c Total persons whose destination excluded)	***Scoring (PSH):*** ***6*** = 15.9% or less ***4*** = **16 - 20.9%** ***2*** = 21 - 25.9% ***0*** = more than 26% ***6 Points Total***	***Scoring (RRH):*** ***6*** = 8.9% or less ***4*** = **9 - 11.9%** ***2*** = 12 - 14.9% ***0*** = more than 15% ***6 Points Total***
B.3 Client Employment Income (Earned Income): *As reported in the APR, the percentage of people aged 18 and older who maintained or increased their earned income at the end of the operating year or project exit, either by maintaining or gaining employment or by increasing the amount of their earned income.*		
Data Autoscored: *APR Qs 19a1, 19a2, 18* (Q19a1 **Number of Adults with Earned Income** Retained and Same + Retained and Increased + Gained + Q19a2 **Number of Adults with Earned Income** Retained and Same + Retained and Increased + Gained) / (Q18 **Total Adults** – Q18 Number of Adult Stayers Not Yet Required to Have an Annual Assessment Number of Adults at Annual Assessment)	***Scoring (PSH):*** ***6*** = 11% or more ***5*** = **8 – 10.9%** ***4*** = 5 – 7.9% ***2*** = 3 – 4.9% ***0*** = less than 3% ***6 Points Total***	***Scoring (RRH):*** ***6*** = 32% or more; ***5*** = **27 – 31.9%;** ***4*** = 22 – 26.9%; ***2*** = 17 – 21.9%; ***0*** = less than 17%; ***6 Points Total***
B.4* Non-employment cash Income*: *As reported in the APR, the percentage of people aged 18 and older who maintained or increased their non-employment cash income at the end of the operating year or program exit.*		
Data Autoscored: *APR Qs 19a1, 19a2, 18* (Q19a1 **Number of Adults with Only Other Income** Retained and Same + Retained and Increased + Gained + Q19a2 **Number of Adults with Only Other Income** Retained and Same + Retained and Increased + Gained) / (Q18 **Total Adults** – Q18 Number of Adult Stayers Not Yet Required to Have an Annual Assessment Number of Adults at Annual Assessment)	***Scoring (PSH):*** ***4*** = 54% or more ***3*** = **49 – 53.9%** ***1*** = 44 – 48.9% ***0*** = less than 44% **4** ***Points Total***	***Scoring (RRH):*** ***4*** = 36% or more ***3*** = **30 – 35.9%** ***1*** = 25 – 29.9% ***0*** = less than 25% **4** ***Points Total***
B.5 Mainstream Benefits: *Please describe how your project will be supplemented with resources from other public or private sources and participants will be assisted in obtaining mainstream health, social and employment benefits (SNAP, SSI/SSDI, Medicare, Medicaid, etc.), and how the project will coordinate the provision of mainstream benefits.*		

Required Submission:	***Scoring:***

Narrative (300-word limit)	***+ 2*** for describing how participants are assisted to obtain mainstream benefits they are eligible for. Detail the partnerships you have established to assist participants with connection to these benefits. ***+ 2*** for describing how the project will be supplemented by other public or private sources, which public and private sources and projected amounts ***4 Points Total***
B.6 Service Participation Requirement: *Please describe your project's approach* to *require project participants to participate in services by contract, occupancy agreement, or lease. Attach your supportive service agreement. Participation requirements must be in line with 24 CFR 578.75(h). Examples of services include case management, employment assistance and job training, life skills training, and substance use disorder treatment.*	
Required Submission: *Narrative (300-word limit)*	***Scoring:*** ***+ 2*** for describing the approach to require participants to participate in services described above **+ 2** for describing partnerships with public or private sources and the resources ($s and % of project budget) these partnerships will bring ***+ 2*** for attaching a compliant supportive services agreement ***6 Points Total***
B.7 High Need Population: *As reported in the APR, the percentage of people served by the project who are high need at entry, including: Disabled Households, Unsheltered Adults, Older Adults (age 65 and over), Adult V*ictims of Domestic Violence or Sexual Assault.	

Data Autoscored: ***a. Disabled Households with 2 and 3 conditions at entry*** *APR Qs 13a2, 8a* **PSH:** (Q13a2 2 Conditions+ Q13a2 3+ Conditions) /Q8a Total Households Served who Moved into Housing **RRH:** (Q13a2 2 Conditions+ Q13a2 3+ Conditions) / Q8a Total Households ***b. Unsheltered Adults:*** *APR Q 15* Q15 "Place not meant for habitation"/ Q5a2 Number of Adults ***c. Older Adults (age 65 and over)*** *APR Q 11* Q11 65+ / Q5a2 Number of Adults ***d. Adult Victims of Domestic Violence or Sexual Assault*** *APR Qs 14a, Q5a* Q14a Yes / Q5a2 Number of Adults	***6 points Maximum*** ***Scoring*** ***Disabled (PSH):*** ***3*** = 81% or more ***2*** = **76 – 80.9%** ***1*** = 71 – 75.9% ***0*** = less than 71% ***3 Points Total*** ***Unsheltered (PSH):*** ***3*** = 40% or more ***2*** = **35 – 39.9%** ***1*** = 29 – 34.9% ***0*** = less than 29% ***3 Points Total*** ***Older Adults (age 65 and over) (PSH):*** ***3*** = 13% or more ***2*** = **10% – 12.9%** ***1*** = 7% – 9.9% ***0*** = less than 7% ***3 Points Total*** ***Adult Victims of Domestic Violence or Sexual Assault (PSH):*** ***3*** = 32% or more ***2*** = **27 – 31.9%**	***6 points Maximum*** ***Scoring*** ***Disabled (RRH):*** ***3*** = 49% *or more;* ***2*** = **44 – 48.9%;** ***1*** = 39 – 43.9%; ***0*** = less than 39%; ***3 Points Total*** ***Unsheltered (RRH):*** ***3*** = 38% or more; ***2*** = **33 – 37.9%;** ***1*** = 28 – 32.9%; ***0*** = less than 28%; ***3 Points Total*** ***Older Adults (age 65 and over)(RRH):*** ***3*** = 13% or more ***2*** = **10 – 12.9%** ***1*** = 7 – 9.9% ***0*** = less than 7% ***3 Points Total*** ***Adult Victims of Domestic Violence or Sexual Assault (RRH):*** ***3*** = 30% or more; ***2*** = **25 – 29.9%;**
	1 = 22 – 26.9% ***0*** = less than 22% ***3 Points Total***	***1*** = 20 – 24.9%; ***0*** = less than 20%; ***3 Points Total***
B.8 Utilization Rate: *As reported in the APR, the average utilization rate during the operating year.*		
Data Autoscored: *APR Q 08b, CoC e-snaps App* **PSH:** (Q08b January + April + July + October)/4 / Project UNIT Capacity ***RRH:*** (Q08b January + April + July + October)/4 / (Project Full Capacity for One Night as Committed in the CoC Application, Screen 5A, Total Number of Households)	***Scoring (PSH):*** ***5*** = 96% or more ***4*** = 93 – 95.9% ***3*** = 90 – 92.9% ***2*** = 87 – 89.9% ***1*** = 84 – 86.9% ***0*** = less than 84% ***5 Points Total***	***Scoring (RRH):*** ***5*** = 84% or more ***4*** = 80 – 83.9% ***3*** = 76 – 79.9% ***2*** = 72 – 75.9% ***1*** = 68 – 71.9% ***0*** = less than 68% ***5 Points Total***

B.9 Monitoring: *Please provide an explanation for any HUD or KVC monitoring letters related to projects open January 1, 2024 to present. These include notices provided by KVC for Sage reporting, quarterly grant spenddown, or data quality, and open monitoring findings from either KVC or HUD.*

Required Submission:	***Scoring (w/ Findings):***	***Scoring (No Findings):***
Narrative and KVC Staff *Narrative (300-word limit)*	***+ 2*** for identified steps to remediate open findings or issues ***+ 2*** for no past due reporting or untimely monitoring activities ***4 Points Total***	***+ 4*** for a project having no open monitoring findings, notices, or delayed submission of required reports ***4 Points Total***

B.10 Grant Spenddown: *Percentage of disbursed HUD funding used for the most recent closed operating year, as reported in SAGE.*

Data Autoscored:	***Scoring:***
Sage	***5*** = 98% – 100% ***4*** = 95% – 97.9% ***2*** = 90% – 94.9% ***1*** = Less than 90% ***5 Points Total***

B.11 Promoting Recovery, Agreements and Commitments: *Please describe your project's approach to promote recovery and commitment to not distribute drug paraphernalia or knowingly permit the use and distribution of fatal, illicit drugs on the property. Confirm the project will not operate drug injection sites or "safe consumption sites," knowingly distribute drug paraphernalia on or off of property under your control, permit the use or distribution of illicit drugs on property under your control, or conduct, permit, encourage or allow any of these activities under the pretext of "harm reduction." This is not a requirement to condition assistance on sobriety or treatment. Acknowledge and certify you will not engage in illegal racial discrimination.*

Required Submission:	***Scoring:***
Narrative (300-word limit)	***+ 1*** for your agreement to not operate the above stated sites, and not distribute or permit the use or distribution of illicit drugs on the property under your control ***+ 1*** for project's commitment to recovery ***+ 1*** for your acknowledgement and certification you will not engage in illegal racial discrimination ***3 Points Total***

B.12 Promoting Recovery**:** *Please describe your project's availability of on-site substance use treatment and if so, the partnership you have with a treatment provider.*

Required Submission:	***Scoring:***
Narrative (300-word limit)	***+ 2*** for project's availability of on-site substance use treatment ***+ 1*** for describing the partnership and naming the treatment provider ***3 Points Total***

B.13 Performance Discretionary: *Agencies may submit a narrative to supplement the performance data above. The narrative should explain why full points were not received and what will be done moving forward to improve upon current project performance.*

Required Submissions:	***Scoring:***
Narrative (300-word limit)	***2*** *= why were full points not received* ***2*** *= what will be done to improve current performance* ***4 Points Total***

PART C: COMMUNITY PRIORITIES

C.1 Lived Experience: *Describe how your project takes proactive steps to ensure the participation of homeless or formerly homeless individuals in decision-making and project design through feedback loops, listening sessions, or leadership opportunities.*	
Required Submissions: *Narrative (300-word limit)*	***Scoring:*** ***+ 2*** for lived experience membership on boards or committees ***+ 1*** for incorporation of lived experience in project design ***3 Points Total***

C.2 Data and HMIS: *As reported in the APR, the percentage of total HMIS fields across all persons served that are missing or in error.*		
Data Autoscored: *APR Qs: 5a, 6a, 6b, 6c, 6d* (Q6a Total errors for Name, Date of Birth, Race/Ethnicity + Q6b Total errors for Project Start Date, Relationship to HoH, Disabling Condition + Q6c Destination, Income and Sources at Start, Annual Assessment, and Exit + 6d Total errors)/ Q5a1 Total Number of Persons Served	***Scoring (PSH):*** ***3*** = less than 19% ***2*** = **19 – 21.9%** ***1*** = 22 – 23.9% ***0*** = more than 24% ***3 Points Total***	***Scoring (RRH):*** ***3*** = less than 22%; **2 = 22 – 24.9%;** ***1*** = 25 – 26.9%; ***0*** = more than 27%; ***3 Points Total***

C.3 Coordinated Entry (CE) Acceptance: *As reported in HMIS, the percentage of eligible referrals accepted by the project from the Family and/or the Singles Coordinated Entry System.*	
Data Autoscored: *HMIS Report*	***Scoring:*** ***3*** = 95% or more ***2*** = 90% – 94.9% ***1*** = 80% – 89.9% ***0*** = Less than 80% ***3 Points Total***

PART D: BONUS POINTS

Bonus points may be awarded based on the criteria below. However, bonus points cannot increase an application's final score above the maximum Total Score established for this application.

D.1 Substance use treatment engagement: *Bonus points are awarded if CoC-funded units require participant engagement in substance use treatment services as a condition of continued participation. Please state your level of commitment to participants' required engagement in substance use treatment services as a condition of continued program participation.*	
Required Submissions: *Narrative (300-word limit)*	***Scoring:*** ***+ 3*** 100% of the units require participant engagement ***+ 2*** At least 50% of the units require participant engagement ***3 Points Max***

Gmail

Traci Strickland <tstrickland@kvccoc.org>

NOFO Prioritization

1 message

Traci Strickland <tstrickland@kvccoc.org> Wed, Sep 23, 2026 at 4:53 PM
To: Megan Payne <mpayne@goodwillsummit.com>, Briana Martin <bmartin@wvcovenanthouse.org>, Michelle Parilac <mparilac@ywcacharleston.org>, Jenny Gossett <gossett@branchesdvs.org>, Jaime Barton <jbarton@ckha.com>, Miranda Nabers <mnabers@rccr.org>, Amanda McComas <mccomas@branchesdvs.org>, Kassi Pauley <kpauley@kvccoc.org>, Julie Britton <jbritton@ywcacharleston.org>, Lindsay Stephens <Lindsay@wefeedpeople.com>, Hunter Bryant <hbryant@ywcacharleston.org>, Christina Hudson <chudson@wvcovenanthouse.org>

On August 6th the KVC Prioritization Committee met and reviewed projects that were submitting NOFO applications.

As always, this is not an easy task.

Here are the results of the Prioritization

Project Name	Score	Status	Rank	Requested Funding Amount	Reallocated Funds
Planning Grant	Not Ranked			$77,627	
HMIS	AutoRank	Accepted	1	$144,287	
CAT	AutoRank	Accepted	2	$100,255	
Shanklin	76%	Accepted	3	$147,298	
COC Housing	75%	Accepted	4	$231,288	
Branches RRH	66%	Accepted	5	$63,738	
Toast	65%	Accepted	6	$251,998	
Resolve TH	62%	Accepted	7	$233,031	$233,031
Shephard	62%	Accepted	8	$240,944	$80,226
Union Mission	62%	Accepted	9	$154,707	
Bridgepoint	58%	Accepted	10	$238,424	$238,424
Twin Cities	31%	Accepted	11	$306,060	
K-ROC		Rejected		$0	
Resolve RRH		Fully Reallocated		$0	($258,948)
RCCR RRH		Fully Reallocated		$0	($54,309)
Housing First		Fully Reallocated		$0	($238,424)

Projects were scored on

Project Summary
Positive Exit Destinations
Returns to Homelessness
Client Employment Income
Non-employment Cash Income
Mainstream Benefits
Service Participation
High Need Population
Utilization Rate

Monitoring
Grant Spending
Promoting Recovery, Agreements
Promoting Recovery on-site
Performance Discretionary
Lived Experience Participation
Data and HMIS
CAT Acceptance
APR Submission (Timeliness)
COC Involvement
Partnerships

--
Traci Strickland
Executive Director
Kanawha Valley Collective
1015 Smith Street
Charleston, WV 25301
304-346-6638

Certification for Opportunity Zones Preference Points

U.S. Department of Housing and Urban Development

OMB Number. 2501-0044
Expiration Date: 2/28/2027

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

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

Applicant Organization:

Assistance Listing number and Federal Program name to which the Applicant is applying:
Include the funding opportunity number and name exactly as it appears in the applicable funding opportunity announcement (example: 14.896, Family Self-Sufficiency Program).

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

The application meets which of the following criteria (please select one):
☐ The proposed activities/projects will occur solely within the Opportunity Zone Census Tract(s) listed above.
☐ The proposed activities/projects will occur within the Opportunity Zone Census Tract(s) listed above and other communities.
☐ The proposed activities/projects will occur outside Opportunity Zone Census Tracts, but substantial and direct benefits will accrue within the Opportunity Zone Census Tracts listed above.

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

Estimated Funding Allocations
Estimate a percentage of the total dollar amount of federal funding awarded that would result in a direct benefit within the Opportunity Zone Census Tracts listed above:
☐ 76% - 100%
☐ 51% - 75%
☐ 26% - 50%
☐ 11% - 25%
☐ 1%- 10%

Provide a narrative explaining and/or reference the section in the application that explains how the project will support public and private investment in urban and economically distressed areas, specifically qualified Opportunity Zones (300-word limit):
Example: "The Main Street project described in this application will stimulate economic opportunity and mobility, encourage entrepreneurship, expand quality educational opportunities, and promote workforce development for those families residing within the XYZ Opportunity Zone."

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

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

Certification of Authorized Representative for the Applicant:
**Under penalty of perjury, I certify on behalf of the Applicant that
(1) all information provided on this form is true, complete, and accurate, and
(2) the Applicant will notify the Agency immediately upon learning of any change in the information provided on this form, and
(3) I am authorized to speak for the Applicant regarding all information provided on this form.

Prefix: First Name: Middle Initial: Last Name: Suffix:

Title: Organization:

Signature: Date: