Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2026 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2026 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It
- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2026 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

1A. Continuum of Care (CoC) Identification

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

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

1A-1. CoC Name and Number: NY-508 - Buffalo, Niagara Falls/Erie, Niagara, Orleans, Genesee, Wyoming Counties CoC

1A-2. Collaborative Applicant Name: Homeless Alliance of Western New York, Inc.

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Homeless Alliance of Western New York, 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	0
3.	Certified Community Behavioral Health Clinic (CCBHC)	Yes	0
4.	Community Mental Health Center (CMHC)	Yes	0
5.	Disability Advocate(s)	Yes	0
6.	Disability Service Organization(s)	Yes	0
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	0
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	1
9.	Faith-based Organzation(s)	Yes	1
10.	Homeless or Formerly Homeless Person(s)	Yes	1
11.	Hospital(s)	Yes	1
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	1
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Yes	0
14.	Law Enforcement	Yes	0
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	0
16.	Local Government Staff/Official(s)	Yes	2

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

1B-2.	Open Invitation for New Members.	

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

(limit 2,500 characters)

The NY-508 Continuum of Care (CoC) maintains a transparent and publicly available process for inviting new members throughout Erie, Niagara, Genesee, Orleans, and Wyoming Counties. Membership is open to individuals and organizations interested in preventing and ending homelessness, including homeless and victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, schools, healthcare and behavioral health providers, social service agencies, courts, law enforcement, workforce and employment organizations, affordable housing partners, organizations serving veterans, and people with lived experience of homelessness.

The CoC Lead Agency, Homeless Alliance of Western New York (HAWNY), maintains membership information and an opportunity to join the CoC on its public website throughout the year. Individuals may join without waiting for a specific annual enrollment period. CoC meetings and other community meetings also provide opportunities for interested individuals and organizations to learn about the CoC and become involved.

In addition to maintaining this year-round public invitation, the CoC conducts outreach at least annually to invite new members and broaden participation. Invitations and information about CoC participation are distributed through HAWNY's website, email communications, newsletters, social media, community events, provider networks, and direct outreach to organizations and community partners across the five-county CoC geography.

HAWNY also uses its ongoing community engagement activities, committees, workgroups, trainings, and partnerships to identify and engage organizations and individuals that may not already participate in the CoC. These efforts help ensure that membership remains open, transparent, and representative of the geographic area and populations served by NY-508.

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)

Our CoC uses an open and transparent process to solicit input on its performance, strategies, and priorities from people with lived experience and organizations with knowledge of or an interest in preventing and ending homelessness. This includes homeless service providers, healthcare and behavioral health systems, substance use treatment and recovery providers, law enforcement and first responders, local government, schools, aging and disability organizations, domestic violence providers, faith-based organizations, businesses, and advocacy organizations. These partners bring different perspectives on the conditions contributing to homelessness.

We hold monthly public CoC meetings open to anyone and gather input through committees, workgroups, surveys, focus groups, interviews, community presentations, and public events. The CoC lead agency also participates in civic, governmental, and community forums throughout the region. People with lived experience participate through the Youth Action Board, Participant Advisory Council, committees, and focus groups. Meetings are offered in ADA-accessible locations and online to provide multiple ways to participate.

Input from these partners is considered alongside CoC data when identifying emerging needs and setting priorities. For example, our data showed an increase in older adults experiencing homelessness. At the same time, law enforcement reported encountering more older adults experiencing street homelessness, while recovery and community providers raised concerns about increasing isolation and loneliness among older adults and how these factors were contributing to housing instability. NY-508 responded by convening federal, state, and local partners for an educational panel focused on older adult homelessness. This led to the formation of an Older Adult Task Force, and the CoC is now exploring shelter options better designed for older adults.

In our rural communities, data and community input identified service gaps, high poverty, and families with children experiencing homelessness. NY-508 increased participation in rural interagency councils and community forums to hear directly from providers and residents, resulting in stronger partnerships and increased education and awareness around rural homelessness and access to services.

Feedback and system data are brought back to CoC leadership, committees, and workgroups and used to review performance, identify gaps, adjust strategies, and establish p

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

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

(limit 2,500 characters)

The CoC Lead publicly posted the local CoC Request for Proposals (RFP) on its website and social media and announced the opportunity at community-wide meetings as well as through email list. The CoC also conducted direct outreach to community partners, stakeholders, faith-based organizations, and organizations that had not previously received CoC Program funding.
To reduce barriers for organizations unfamiliar with the CoC Program, CoC Lead staff provided workshops on the NOFO, eligible project models, local requirements, and application process. Staff also provided extensive one-on-one technical assistance to new applicants, including assistance with e-snaps. These efforts resulted in 20 new project applications, including applications from five organizations that do not currently receive CoC Program funding.
Applicants are not required to be existing CoC-funded organizations or CoC members to apply or be considered for funding.
The RFP provides clear submission instructions, deadlines, and review criteria. Proposals are submitted through a Google Form or in Word/PDF format by email to the CoC Lead by the published deadline. New project applications are evaluated based on the applicant's relevant experience and organizational capacity, proposed program design and alignment with HUD requirements, and demonstrated community need. Applications are reviewed by the CoC's independent Project Selection Committee, whose members do not have conflicts of interest with the projects under consideration. The Committee evaluates applications using the established local review criteria and makes funding and project selection decisions.

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)

In FY2026, approximately 8,602 people experienced homelessness in NY-508. CoC-funded housing programs serve 3374 people annually, but with only a 19% annual turnover rate, approximately 644 openings are available to new participants—enough to serve only about 7% of people experiencing homelessness. Needs are diverse: 520 people experienced chronic homelessness, 1,952 reported a mental health disorder, 996 a substance use disorder, 1,046 were age 55 or older, 747 were youth, and 744 experienced unsheltered homelessness. These data and provider feedback demonstrate gaps in housing capacity and the need for targeted interventions.

The CoC will combine federal, state, local, healthcare, and community resources. CoC-funded PSH and RRH will continue prioritizing people experiencing homelessness the longest, with PSH serving people with disabilities and RRH assisting households able to return to independent housing. New FY2026 TH projects will expand structured housing and services, including programs for people with substance use disorders. State-funded supportive housing, including ESSHI, targets frail older adults, youth under 25, people with serious mental illness, and people with substance use disorders.

Medicaid and mainstream benefits connect people to healthcare, behavioral health services, and income supports that can prevent homelessness or accelerate shelter exits. PHA partnerships provide direct referrals to Housing Choice Vouchers for households needing long-term rental assistance without supportive services. Healthcare partners provide on-site services to address conditions that delay housing placement and support housing stability. Faith-based partners expand emergency shelter and services to reduce unsheltered homelessness. The CoC has also proposed using local opioid settlement funds for targeted outreach to unsheltered people in downtown Buffalo with substance use and behavioral health needs.

During FY2027, the CoC will implement newly funded projects and monitor outcomes quarterly. Targets include reducing chronic homelessness by 5%, overall homelessness by 20%, and continuing reductions in unsheltered homelessness through coordinated shelter, outreach, and law-enforcement partnerships. HAWNY and the CoC Board will oversee implementation and quarterly review using HMIS, Coordinated Entry, System Performance Measures, and project outcomes to identify additional capacity needs and guide future funding priorities.

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?	31%

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)

N/A

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)

Our CoC partners with and funds projects operated by established behavioral health and substance use disorder (SUD) providers, including BestSelf Behavioral Health, Spectrum Health & Human Services, and Cazenovia Recovery Systems. Many of these agencies operate both CoC housing and community behavioral health/recovery programs, allowing individuals to access treatment regardless of whether they are housed or enrolled in a CoC-funded project.

Treatment resources are integrated throughout our homeless response system. Coordinated Entry, shelters, Street Outreach, hospitals, law enforcement, and housing providers are familiar with community treatment resources and referral pathways, creating multiple access points for people who are sheltered, unsheltered, or housed.

Through these partnerships, individuals can access a range of outpatient mental health and SUD care, including diagnostic assessment, individual and group psychotherapy, mental health and SUD counseling, intensive outpatient treatment, psychiatric services, and community-based behavioral health treatment. Psychosocial interventions include Cognitive Behavioral Therapy, Motivational Interviewing, trauma-informed treatment, relapse prevention, psychiatric rehabilitation, case management, and peer services.

Medication management is available through psychiatric evaluation, prescribing, monitoring, and clinically appropriate medication-supported treatment. Our treatment network also includes 24/7 detoxification services when withdrawal management or a higher level of care is clinically indicated, with connections to outpatient treatment and ongoing recovery services.

Suicide prevention and crisis intervention are integrated throughout the network. Local providers offer 24/7 crisis services, and New York's 988 Suicide & Crisis Lifeline provides 24/7 call, text, and chat crisis support. Individuals can also access safety planning, mobile crisis, crisis stabilization, emergency psychiatric services, and follow-up outpatient care.

Recovery supports include peer recovery services, relapse prevention, psychiatric rehabilitation, care coordination, life-skills services, and community recovery resources. BestSelf provides outpatient treatment through its CCBHC network; Spectrum provides outpatient mental health and SUD services; and Cazenovia provides SUD treatment and recovery services with connections to outpatient care.

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)

NY-508 partners with behavioral health, substance use treatment, healthcare, housing, recovery, and county systems that use Certified Recovery Peer Advocates (CRPAs) and other trained peer specialists with lived experience. CoC partners including BestSelf Behavioral Health, Endeavor Health Services, and Cazenovia Recovery Systems utilize peers, and the Department of Health also conducts community outreach using peer staff.

Peer support can begin before an individual enters treatment or housing. Outreach teams use peers to engage individuals in the community, including people experiencing unsheltered homelessness who may be hesitant to engage with traditional systems. Peers use lived experience to build trust, identify the individual's goals, and help determine the next step. When someone is ready for treatment, housing, or another service, peers and outreach staff provide warm handoffs and help navigate the connection rather than simply providing a referral or phone number.

Peers and CRPAs provide one-to-one and group support, recovery planning, advocacy, appointment preparation, and assistance navigating behavioral health and substance use systems. They can connect or accompany individuals to outpatient or residential treatment, MAT, healthcare, crisis services, recovery groups, benefits, transportation, housing, and other community resources.

Peer recovery specialists complement clinical services by helping participants navigate complex systems. Peer support is also especially important during transitions. Peers can remain involved as someone moves from the street to treatment, between levels of care, or into housing. If someone disengages from treatment or experiences a return to use, peers can continue engagement and help reconnect the individual to treatment and recovery.

Peer support can also continue after housing. Peers work alongside case managers, clinicians, outreach staff, and housing providers to strengthen recovery supports, reduce isolation, build community connections, and support continued engagement in treatment and housing.

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)

NY-508 has a community-wide process for identifying individuals experiencing or potentially experiencing Serious Mental Illness (SMI) and connecting them to services needed to promote stability. Individuals may be identified through Street Outreach, Coordinated Entry (CE), shelters, housing programs, hospitals, and case conferencing. In FY2025, 1,952 individuals experiencing homelessness reported a mental health condition.

CE access points and Street Outreach teams are trained to identify indicators of significant mental health needs and initiate referrals to the County Departments of Mental Health Single Point of Access (SPOA), the centralized referral system for behavioral health services. Staff assist with referrals rather than requiring individuals to navigate the behavioral health system independently. SPOA also receives referrals from hospitals, care coordination and clinical providers, family members, and other community partners.

SPOA scores referrals based on risk and triages individuals to the appropriate level of care. Connections may include Assertive Community Treatment (ACT), Assisted Outpatient Treatment (AOT), licensed residential housing, CoC-funded housing, and other supportive housing and community-based services. Erie County's ACT/FACT system currently has 468 treatment slots, including Spectrum's expansion from 68 to 100 slots, increasing access to intensive community-based treatment.

Coordination continues beyond referral. SPOA representatives participate in CE, homeless outreach, CoC, and other community meetings where high-need individuals are identified and coordinated across systems. SPOA also participates in meetings focused on vulnerable individuals, including Comprehensive Psychiatric Emergency Program high-utilizer, AOT, and SPOA meetings. The CoC/CE Lead participates in monthly hospital/SPOA case conferencing to address barriers and coordinate treatment, care management, housing, or higher levels of care.

For acute psychiatric needs, partners connect individuals to 988, mobile crisis, crisis stabilization, emergency psychiatric evaluation, or hospitalization, with coordination back to community-based treatment and housing supports following stabilization.

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 Erie County Department of Mental Health (DMH), a CoC grantee that administers Assisted Outpatient Treatment (AOT). DMH also partners with the University at Buffalo through a Bureau of Justice Assistance grant serving Adult Drug Treatment Court participants in the 8th Judicial District, providing assessment, case management, peer support, and connections to mental health, substance use, health, and other services.

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)

NY-508 coordinates closely with Erie County Department of Mental Health (ECDMH), a CoC grantee and partner connecting behavioral health, specialty court, and housing systems. ECDMH administers Assisted Outpatient Treatment (AOT) and Adult Single Point of Access (SPOA), the county behavioral health system's centralized pathway for connecting individuals with significant mental health needs to appropriate services.

SPOA connects individuals to Assertive Community Treatment (ACT), Health Home/care management, AOT, mental health housing, and other community-based services. Our CoC lead, Coordinated Entry (CE), ECDMH, treatment providers, hospitals, and housing partners coordinate referrals and case conferencing to identify both behavioral health and housing needs and connect individuals to the appropriate services and housing.

When homelessness or housing instability is identified, CE and partners assist with assessment, documentation, benefits, referrals, and warm handoffs to housing. Options are not limited to CoC-funded programs and may include PSH, OMH-funded supportive or mental health housing, public housing, vouchers, and other community resources based on eligibility and need.

For individuals subject to AOT court orders, ECDMH leverages the AOT process to provide priority access to ACT teams, Health Home care management, and residential programs within the behavioral health system. ACT and care coordination teams provide more frequent supports to help individuals remain engaged in services and work toward housing and other goals, including connection to vocational and other resources that promote independence. When individuals are no longer a regulatory fit for AOT, they may participate in Enhanced Voluntary Agreements, which provide similar levels of support without continued court involvement.

ECDMH also partners with the 8th Judicial District Adult Drug Treatment Court and University at Buffalo to address participants' mental health/SUD needs and other barriers through assessment, case management, and peer support. When housing instability is identified, participants can be connected to CE and housing resources.

Together, this coordination aligns court-connected treatment, behavioral health services, and housing resources to support housing stability and movement toward independence.

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

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

(limit 500 characters)

The CoC partners with Erie County Dept. Mental Health, a CoC grantee that funds Suicide Prevention and Crisis Services (SPCS), Erie County's 988 provider, for telephonic crisis response and mobile crisis outreach. SPCS participates in SPOA meetings and collaborative case conferencing for high-need individuals. The CoC also partners with BestSelf Behavioral Health, a CoC grantee operating the Crisis Stabilization Center serving the CoC region.

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.	109

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)

NY-508 has formal partnerships with CCBHCs BestSelf Behavioral Health, Spectrum Health & Human Services, and Community Health Center of Buffalo (CHCB). BestSelf and Spectrum have MOUs to provide behavioral health services to CoC participants. CHCB provides on-site clinical treatment and recovery services at shelters and housing programs through its Mobile Health Center and integrated behavioral health/CCBHC services.

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

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

(limit 500 characters)

The CoC includes two new CoC Program-funded Transitional Housing projects operated by Cazenovia Recovery Systems and Buffalo City Mission that will operate sober housing in accordance with 24 CFR 578.93(b)(5).

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)

Our CoC coordinates with treatment, recovery, healthcare, crisis, and housing providers to ensure individuals participating in or exiting programs described in 1C-1a through 1C-1i are connected to appropriate housing resources and do not enter or return to homelessness.

CE serves as a central connection point between treatment and recovery programs and the housing response system. When an individual participating in treatment, recovery, healthcare, or crisis services is experiencing homelessness or housing instability, the referring provider works directly with CE and housing partners to identify a housing pathway and support the transition. Warm hand-offs may include provider-to-provider communication, information sharing with consent, assistance with documentation and assessments, coordination of next steps, and twice-monthly case conferencing to address barriers and facilitate housing placement.

The CoC Lead and CE Lead have extensive knowledge of CoC-funded housing and the broader supportive and affordable housing system. Housing planning is not limited to CoC-funded PSH, RRH, or TH. During case conferencing, CE and partners identify alternative housing pathways based on their age, disability, behavioral health/SUD history, income, eligibility, and support needs. Options may include state-funded supportive housing, including programs serving people with mental health or SUD needs; HCV; other supportive housing; and community-based housing resources.

To prevent entry into homelessness, housing and discharge planning begins before an individual leaves treatment, detoxification, hospitalization, crisis stabilization, residential care, or another institutional setting when the individual lacks safe housing. Providers coordinate with CE, shelters, outreach, housing providers, and other community resources before discharge to identify a safe housing destination. When permanent housing is not immediately available, partners identify an interim placement while continuing to pursue permanent housing.

Warm hand-offs continue beyond referral. CE and housing providers coordinate directly with treatment/recovery partners to address documentation, benefits, eligibility and placement barriers and connect participants to housing navigation and available units. Treatment and recovery providers remain involved when appropriate as participants transition into housing, supporting continuity of treatment, medication management, and recovery services.

1C-2.	Supportive Services Investment.	

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	$24,661,760
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.	$8,994,230
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	36%
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.	$7,739,162

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).	68%

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

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

1C-4. Consulting with ESG Recipients.

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

(limit 2,500 characters)

The CoC consults with the five ESG recipients serving the CoC geography: the City of Buffalo, Erie County, City of Niagara Falls, and New York State Office of Temporary and Disability Assistance (OTDA). The CoC Lead works with recipients during ESG planning and allocation processes by providing data on homelessness trends, system needs, service gaps, and project performance to inform funding priorities and subrecipient selection.
The CoC provides PIT and HIC data, shelter occupancy and utilization data, HMIS performance reports, housing outcomes, Annual Reports, and customized analyses requested by ESG recipients. The CoC/HMIS Lead also supports ESG reporting, including CAPER reports, and reviews data with recipients to identify gaps and determine where ESG resources can have the greatest impact. CoC staff participate in ESG funding and subrecipient selection processes when requested and provide feedback on homelessness-related portions of Consolidated Plans.
Consultation continues after funds are allocated. The CoC monitors and reviews ESG-funded project performance, shares performance data with recipients, and works jointly with recipients and subrecipients to address performance or system coordination concerns. The CoC also collaborates with ESG recipients on performance measures and provides county-specific and other customized reports to support ongoing planning.
The CoC will continue regular consultation with ESG recipients through data sharing, funding-planning discussions, performance review, Consolidated Plan consultation, and coordination with ESG-funded providers to ensure ESG investments respond to changing needs across the CoC geography.

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 NY-508 Continuum of Care maintains a coordinated approach to connecting individuals and families residing in emergency shelters to permanent housing resources through its Coordinated Entry (CE) System. All emergency shelters are either participating in Coordinated Entry by conducting the standardized assessments or CE staff are sent to these shelters to conduct the assessment to ensure clients are connected to CoC resources.
Emergency shelter providers work closely with Coordinated Entry staff to ensure participants are assessed promptly, entered into HMIS, and connected to available Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), Transitional Housing (TH), Joint TH-RRH, and other appropriate housing resources based on program eligibility and participant needs. Referrals are made through the Coordinated Entry process in accordance with the CoC's Written Standards to ensure fair, transparent, and consistent access to housing resources.
HAWNY, as the Coordinated Entry Lead Agency, provides ongoing oversight, technical assistance, and training to shelter providers while facilitating regular case conferencing and system coordination meetings. These meetings allow providers to review households with the highest barriers to housing, coordinate available resources, resolve placement barriers, and promote timely exits from shelter to permanent housing.
In addition to CoC-funded housing, the CoC Lead assists shelter providers in building partnerships to better connect participants to mainstream benefits, Medicaid, public and unsubsidized housing, Housing Choice Vouchers, state and local housing resources, behavioral health services, employment supports, and other community resources that promote housing stability. Through this coordinated approach, the CoC seeks to increase successful exits to permanent housing.

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 routinely shares PIT, HIC, HMIS, and System Performance Measures data with state and local governments, as permitted by law, to inform planning, resource allocation, performance improvement, and development of the homelessness response system. The CoC/HMIS Lead also provides shelter utilization, housing outcomes, and customized analyses based on the needs of government partners.
Data are shared with the City of Buffalo, Erie County, City of Niagara Falls, Town of Tonawanda, New York State agencies, and other local government partners through published reports, presentations, planning meetings, Consolidated Plan consultation, funding processes, and customized data requests.
The Homeless Alliance annually publishes a comprehensive Homelessness Summary Brief on its website, making CoC data accessible to government partners, service providers, funders, and the broader community. The report uses HMIS and community data to examine the number of people experiencing homelessness, multi-year trends, demographics and special populations, prior living situations, causes of housing loss, housing affordability, exit destinations, and system performance. It identifies emerging needs and challenges and provides policy recommendations to support community planning and strategies to reduce homelessness.
The CoC also participates in the New York State Homeless Assistance Datawarehouse Environment (NYSHADE), administered by the New York State Office of Temporary and Disability Assistance (OTDA). Through NYSHADE, the CoC submits HMIS-derived data that contribute to statewide analysis of homelessness trends, service gaps, mobility patterns, and resource needs. NYSHADE is specifically designed to support statewide planning, policy, and resource allocation.
Data shared for system planning and analysis are provided in aggregate or de-identified form. Personally identifiable information (PII) is not shared for general planning purposes, protecting client confidentiality, privacy, and data security in accordance with applicable HMIS requirements. NYSHADE similarly de-identifies client records so that OTDA and participating agencies access only de-identified aggregate data.

The CoC uses these ongoing data-sharing relationships to help state and local partners identify needs and gaps, establish funding priorities, develop programs and policies, and improve the homelessness response system.

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

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

(limit 2,500 characters)

The CoC uses information from other public systems alongside HMIS to support individual-level service coordination, avoid duplication of services, and connect participants to the resources best suited to meet their needs. Authorized staff and partner agencies use information available through their respective systems to coordinate housing, benefits, health care, and supportive services.
Certain Coordinated Entry staff are trained and authorized to access Medicaid information and use that information alongside HMIS to coordinate eligible services. For example, when an individual qualifies for both CoC-funded housing and Medicaid-funded services, staff can coordinate across the two systems to determine which resources can most appropriately meet the participant's needs, avoid duplication, and maximize available supports.
Local Departments of Social Services (DSS) also participate in HMIS. Authorized DSS staff can view relevant homelessness services received by clients and use that information when coordinating shelter access, housing, public benefits and other services, improving continuity across the homelessness and mainstream service systems.
The CoC also uses public health data to inform system-level planning and outreach. Erie County Department of Health heat maps and other available data related to substance use and overdoses help identify geographic areas experiencing increased activity or emerging hotspots. The CoC can compare these trends with known unsheltered locations and information from outreach partners to identify areas where additional engagement, behavioral health resources, treatment connections, or coordinated responses may be needed.The CoC also uses information from 311 and 911 calls to help identify individuals experiencing unsheltered homelessness and locations where outreach may be needed. Coordinated Entry and outreach partners work with law enforcement and other first responders to connect individuals identified through these systems with appropriate homelessness, housing, and supportive services.
These practices allow the CoC to use information beyond HMIS in day-to-day care coordination, reduce duplication across publicly funded systems, and connect people experiencing homelessness to the combination of housing, benefits, health, and supportive services most likely to support housing stability.

1C-6. Employment and Workforce Development Partnership.

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

(limit 2,500 characters)

NY-508 has formal workforce development partnerships with Northland Workforce Training Center and Erie 1 BOCES Workforce Development. Both partnerships are formalized through Memorandums of Understanding (MOUs) with HAWNY, the CoC Lead Agency, and provide a direct pathway for individuals experiencing homelessness to education, workforce training, and employment opportunities.
Northland Workforce Training Center provides industry-driven workforce training in advanced manufacturing, skilled trades, and energy. Participants can access certificate and degree programs through Northland's educational partners, along with career coaching, internships, apprenticeships, co-ops, job placement, and employment retention support. Northland also works to address barriers such as transportation, childcare, academic readiness, and affordability that can prevent individuals from successfully completing training and entering employment.
Erie 1 BOCES Workforce Development provides adult education and career training in healthcare, skilled trades, and manufacturing. Programs include LPN, phlebotomy, CNC machining, electrical, HVAC, plumbing, and welding. Erie 1 BOCES also provides free GED and English-language classes, career advising, resume and interview assistance, job-search support, and employer referrals.
Through these MOUs, HAWNY and CoC providers can identify individuals who need employment, education, or training and connect them directly to the appropriate workforce partner. This allows the homeless response system to focus on housing stability while established workforce partners provide the education, training, and employment services needed to increase earned income and long-term housing stability.
Our CoC will continue to use these formal partnerships to strengthen connections between Coordinated Entry, shelter, outreach, housing, education, and employment.

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

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

(limit 2,500 characters)

NY-508 works closely and cooperates with law enforcement and first responders to ensure interactions with individuals experiencing unsheltered homelessness to create opportunities for engagement, housing, and services rather than having multiple systems respond in silos, and to allow for accountability.
The CoC developed a shared unsheltered location mapping system that is available to law enforcement and outreach partners. The map identifies locations where unsheltered individuals are being reported, where outreach is already occurring, and where additional support may be needed. This allows partners to coordinate responses, avoid duplicative contacts, and connect individuals with outreach workers who can build relationships and provide access to housing and services.
We also use calls coming through 311 and referrals from law enforcement and first responders to identify individuals and locations that may need outreach and additional support; outreach staff respond alongside law enforcement. This co-response allows law enforcement to assist with safety and the initial connection while outreach staff focus on, identifying immediate needs, offering shelter, and connecting individuals to Coordinated Entry (CE), housing, treatment, medical and behavioral health services, benefits, and other supports. It also gives individuals an opportunity to interact with law enforcement in a setting where outreach and service options are immediately available.
The CoC Lead also convenes monthly meetings with local law enforcement agencies, transit police, outreach providers, and other partners to coordinate responses to unsheltered homelessness. During these meetings, we discuss areas where we are seeing increased needs as well as individuals who are having repeated interactions with law enforcement or first responders. We review whether the individual has been engaged, their current housing or service status, barriers that remain, and next steps. These meetings give first responders a direct connection to the CoC's outreach and housing system and provide a mechanism for reconnecting individuals with appropriate services.
As these partnerships have developed, law enforcement has become an important referral source into the CoC. Officers and first responders have a direct connection to the CoC lead, CE lead and outreach teams and can bring outreach into situations where an individual may otherwise never have connected with the homeless response system.

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 assist individuals and families experiencing homelessness in identifying safe opportunities to reunify with family members and other natural support networks when appropriate and desired by the participant. Reunification is incorporated into housing and service planning and may include identifying and contacting family or other supports, assessing whether reunification is safe and appropriate, coordinating with providers or resources in another geographic area, and assisting with transportation and other needs necessary to facilitate reunification.
Family reunification is a particularly important component of the CoC's response to youth homelessness. Compass House, a youth-serving provider and active CoC partner, works with youth experiencing homelessness or housing instability to address family conflict, strengthen family and natural-support connections, and facilitate safe reunification when appropriate. Through crisis counseling, family counseling, case management, and individualized support, Compass House helps youth and their families address conflicts that may have contributed to housing instability and identify whether returning to or reconnecting with family or another supportive adult can provide a safe pathway out of homelessness.
Across the broader homeless response system, providers similarly explore family and support networks as part of individualized case management and housing planning. When reunification outside the immediate area is appropriate, providers assist participants in coordinating the transition and connecting with resources at the destination.
Local Departments of Social Services (DSS) across the CoC's five-county geography also incorporate family and natural supports into homelessness diversion and housing planning. DSS staff explore whether an individual or family can safely stay with relatives, friends, or other supportive persons as an alternative to entering or remaining in emergency shelter. When reunification is appropriate, DSS may provide transportation to help individuals and families reunify with supports, including outside the local area. DSS may also help households identify available supports, shared housing arrangements, and other assistance that can make the arrangement sustainable. These efforts provide additional safe housing options and strengthen existing support networks while preserving access to emergency shelter when needed.

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

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

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

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

(limit 2,500 characters)

NY-508 cooperates with and does not interfere with or impede local efforts to advance public safety, including clearing tents and encampments, decreasing public use of illicit drugs, utilizing applicable standards to address individuals who may be a danger to themselves or others, and sharing information in accordance with Sex Offender Registry and Notification Act (SORNA) requirements. The CoC respects the authority and responsibilities of municipalities, law enforcement, first responders, and other authorized agencies while assisting individuals experiencing homelessness in accessing services.
When a municipality or law enforcement determines that a tent or encampment must be cleared, local partners coordinate with the CoC Lead Agency so outreach workers can be deployed before the clearing occurs. Outreach staff engage individuals and offer available shelter, Coordinated Entry, housing, treatment, healthcare, behavioral health services, and other resources. The CoC does not interfere with the local government's decision to clear the site; its role is to help individuals connect with services before and during the response.
The CoC also coordinates directly with law enforcement, EMS, 988, Mobile Crisis, hospitals, DSS, behavioral health and substance use treatment providers, and other partners. First responders can contact the CoC Lead Agency or outreach providers when they encounter an individual experiencing homelessness who needs assistance, including individuals using illicit drugs in public or experiencing an overdose. Outreach connects individuals to appropriate treatment, harm reduction, healthcare, shelter, housing, and other services while public safety partners address the immediate situation.
When an individual may present a danger to themselves or others, the CoC assists with service connections while law enforcement, Mobile Crisis, hospitals, and other authorized professionals apply applicable standards and determine appropriate interventions, including involuntary commitment when legally warranted. The CoC does not impede these determinations.
The CoC also cooperates with applicable SORNA requirements and does not interfere with required registration, notification, or lawful information-sharing by responsible agencies.
Through these partnerships, NY-508 supports local public safety efforts while providing first responders direct access to outreach and CoC services for individuals experiencing homelessness.

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

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

(limit 2,500 characters)

NY-508 works to protect public safety while ensuring people living in tents or encampments are quickly connected to shelter, housing, treatment, or other appropriate services. Municipalities and law enforcement determine when action is necessary on public property, while the CoC works with these partners to incorporate Street Outreach (SO) as early as possible.
City Code §309-36 prohibits tents or temporary structures in City parks or open spaces without Common Council permission. City park rules establish operating hours, while City Code §§413-5 and 413-8 address obstruction of streets, sidewalks, and other public spaces. When these provisions require action, the CoC coordinates with municipal and law-enforcement partners so enforcement is paired with outreach and connection to services. When possible, SO receives advance notice and conducts repeated engagement before a location is cleared.The intent is not simply to remove a tent or relocate someone to another public space, but to use the intervention to resolve their unsheltered homelessness. In FY2025, 57.18% of SO exits were to successful destinations, up from 43.04% in FY2024.
A major barrier identified through outreach and provider experience is that appropriate placement is not always immediately available. NYS Temporary Housing Assistance requirements under 18 NYCRR §352.35 can result in assistance being denied, discontinued, or subject to a disqualification period. Medical, behavioral health, accessibility, or documentation needs may also prevent placement in traditional shelter, while insurance, clinical eligibility, and bed availability can delay substance use treatment or higher levels of care. When barriers occur, the CoC works with DSS, treatment, healthcare and shelter providers, law enforcement, and other partners to resolve barriers or identify alternatives. SO remains engaged rather than allowing a denied shelter or treatment placement to end the response. Through shared mapping, advance notice, repeated engagement, and partner coordination, the CoC works to resolve encampments quickly while reducing displacement from one outdoor location to another.

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

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

(limit 2,500 characters)

NY-508 does not currently have large-scale encampments. Because the NOFO does not define an encampment, for purposes of this application the CoC defines an encampment as a known outdoor location where three or more individuals are residing together. Locations occupied by one or two individuals are tracked and served by Street Outreach but are not classified as encampments. No identified encampment has exceeded 15 individuals, reflecting the smaller, dispersed nature of unsheltered homelessness in our geography.

Currently, the CoC is tracking 11 active encampments, compared with 35 last year; a 68.5% reduction. The CoC has significantly strengthened its mapping and monitoring of unsheltered locations over the past year. Street Outreach, law enforcement, 311, community partners, and residents help identify new locations and provide updates on known sites. A shared mapping process tracks active, resolved, and inactive locations and identifies where additional outreach is needed. Regular coordination and case conferencing meetings with outreach providers and community partners are used to review locations, share updates, coordinate engagement, and identify next steps. These efforts have provided a more accurate and timely understanding of where unsheltered homelessness is occurring.

Current tracking further demonstrates how dispersed the population is. Eighty-seven known outdoor sites that have been resolved or marked inactive were single-person locations and therefore were not encampments. New individual tents and small locations continue to emerge even as others are resolved, requiring ongoing monitoring and engagement.

The CoC has also strengthened its approach to Street Outreach with a greater focus on helping individuals move from unsheltered homelessness toward housing and stability. Teams address immediate needs while focusing engagement on shelter, housing, treatment, healthcare, employment, and other services. We have increased outreach teams' knowledge of available housing options, treatment and higher levels of care, employment resources, and the steps necessary to move someone from the street toward permanent housing. Each engagement is an opportunity to address immediate needs while continuing to work toward a longer-term solution.

Overall, our CoC continues to experience primarily individual tents and small outdoor locations, with a limited number meeting the CoC's definition of an encampment and no large-scale encampments.

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)

Erie County Executive Order #014 established the Opioid Epidemic Task Force to coordinate law enforcement, health and mental health agencies, treatment providers, social services, healthcare, and community partners. The CoC leverages this coordinated response to address public-safety concerns and connect individuals to treatment and recovery services. New York Mental Hygiene Law §22.09 allows intervention when substance use incapacitates an individual and there is a likelihood of harm to the individual or others. New York's 911 Good Samaritan Law also reduces barriers to requesting emergency assistance during an overdose.
Locally, Street Outreach uses direct observation, law-enforcement and community reports, overdose data and mapping, and known unsheltered locations to identify areas experiencing public drug use. Law enforcement addresses unlawful activity and immediate safety concerns, while outreach and treatment partners connect individuals to detoxification, substance use treatment, behavioral healthcare, shelter, housing, and recovery services.
Local data indicate that approximately 9% of people experiencing homelessness report a drug use disorder, including approximately 12% of people identified through the unsheltered PIT Count. These data support targeted intervention rather than assuming substance use is universal among people experiencing homelessness. After outreach and law enforcement encountered women experiencing homelessness and public drug use while engaged in commercial sex, including individuals experiencing trafficking or exploitation, the CoC Lead coordinated with law enforcement, Drug Court, treatment, shelter, and victim-service partners to establish direct pathways to treatment beds, shelter, and trafficking services.
However, public drug use alone does not necessarily meet the legal threshold for involuntary emergency intervention under §22.09. Treatment may also be delayed by clinical eligibility, level-of-care determinations, insurance authorization, bed availability, prior discharge, or complex co-occurring conditions. The CoC addresses these barriers through direct coordination among outreach, law enforcement, treatment, healthcare, shelter, and other partners. When one option is unavailable, partners identify another provider, level of care, detoxification service, emergency placement, or other appropriate response while continuing engagement.

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)

NY-508 recognizes overdoses and illicit drug use in public spaces as an ongoing public health and safety concern across the CoC's urban, suburban, and rural communities. While fatal overdoses are declining in portions of the CoC, trends vary across the region, the substances involved are changing, and the population most affected is aging.

Available public health data do not separately identify overdoses occurring in public spaces, so the CoC uses broader overdose data alongside information from Street Outreach, law enforcement, and community partners to understand conditions in public spaces. In the CoC’s largest population center, fatal overdoses decreased 18%, from 436 in 2023 to 358 in 2024, while opioid-related fatalities decreased 26%, from 366 to 272. Overdose deaths continued to decline in 2025, while reported nonfatal overdoses remained relatively stable. Trends elsewhere in the CoC vary, with some areas reporting decreases and others increases.

The population affected is also changing. Adults age 50 and older accounted for 46% of overdose deaths in Erie County in 2024, compared with 21% in 2016. This is relevant to the homeless response system as the CoC is also encountering an aging unsheltered population with overlapping substance use, medical, behavioral health, and housing needs.

The substances involved are changing as well. Fentanyl remains a significant concern, while public health data show increasing involvement of cocaine and other substances in overdose deaths, adding complexity to prevention, treatment, and overdose response.

Although overall overdose trends are improving, public drug use and overdoses continue to occur in some public spaces. Street Outreach, law enforcement, and community partners continue to identify public drug use in some parks, transportation areas, unsheltered locations, and other public spaces. These observations provide important context because available public health data do not separately identify overdoses occurring in public spaces. Individuals encountered in these settings may also have behavioral health, medical, housing, or other needs that require coordinated intervention.The CoC continues to monitor these conditions and use targeted outreach and coordination where public drug use is identified.

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)

NY-508 works closely with law enforcement, 988, Mobile Crisis, EMS, hospitals, and behavioral health providers when an individual experiencing homelessness presents an immediate safety concern. New York Mental Hygiene Law §9.41 allows law enforcement to transport an individual for emergency psychiatric assessment when the legal standard is met. Under §9.58, qualified Mobile Crisis professionals may also initiate transport for evaluation when statutory criteria are met.
Outreach staff do not determine whether someone should be involuntarily transported or hospitalized. They identify concerns, engage the individual, and bring in appropriate crisis, law-enforcement, medical, or behavioral-health professionals to assess the situation.
Local data demonstrate substantial use of this crisis-response system. Crisis Services' Mobile Outreach team provided mental-health assessment and intervention to 4,897 individuals in 2023, and 81% of crisis hotline calls were diverted from requiring 911. In 2024, approximately 10,000 people presented to ECMC's emergency department for behavioral-health emergencies, with nearly half transported by police or ambulance. While not specific to people experiencing homelessness, these data demonstrate the scale of the crisis-response resources available to the CoC.
A limitation is that not every concerning situation meets the legal standard for involuntary intervention. Individuals may be deteriorating, repeatedly using emergency services, or struggling to safely care for themselves without meeting the standard at that moment. Assisted Outpatient Treatment under §9.60 provides another pathway when eligibility criteria are met. Qualitative experience from Street Outreach and hospital coordination shows a recurring challenge when individuals experiencing homelessness are medically or psychiatrically cleared for discharge but lack an appropriate setting to meet significant medical, behavioral health, cognitive, or mobility needs.
The CoC mitigates these gaps through coordination among outreach, hospitals, behavioral health, housing, healthcare, aging services, and other partners. The CoC works with hospitals on frequent emergency use and discharge barriers, and outreach can engage individuals before discharge. When emergency criteria are not met, partners continue engagement and work to identify an appropriate intervention rather than waiting for another crisis.

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)

Our CoC coordinates with law enforcement, probation/parole, DSS, shelter providers, outreach teams, and other partners to support compliance with federal SORNA requirements and NY State's Sex Offender Registration Act (SORA). NY requires registered sex offenders (RSOs) to maintain registration information and report address changes.
Local laws and practices support public safety and information sharing. Under 18 NYCRR 352.36, local social services districts must consider sex-offender status when placing individuals in Temporary Housing Assistance (THA). County maintains SARA-compliant hotel capacity specifically for RSO placements so households with children are not placed at the same shelter location. DSS also maintains a direct relationship with NYS DOCCS to ensure shelter sites comply with geographic restrictions.
County DSS screens applicants during the THA application and interview process and searches the NYS Division of Criminal Justice Services Sex Offender Registry and County Sheriff's Office OffenderWatch system. There are currently 28 RSOs in THA placements. This quantitative information, together with DSS and shelter experience, supports continued screening, designated placement capacity, and coordination with law enforcement and DOCCS to protect public safety while maintaining shelter access.
State law, registries, and local information systems provide multiple avenues for sharing RSO status and shelter-location information with appropriate CoC providers and law enforcement. A potential limitation is balancing information sharing with federal and state confidentiality requirements, including HMIS protections; protected information must be shared only when permitted or required.
The CoC will leverage existing DSS screening, SARA-compliant placement capacity, registries, OffenderWatch, and direct coordination with DOCCS and law enforcement. HAWNY will continue working with DSS, shelters, outreach, probation/parole, and law enforcement to support appropriate placement, registration compliance, lawful information sharing, and provider understanding of SORNA/SORA requirements.

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)

NY-508 covers a large geographic area with urban, suburban, and rural communities, so outreach cannot look the same everywhere. Our strategy is to create as many ways as possible for someone experiencing homelessness to be identified, assessed, and connected to housing and services.
We use a No Wrong Door approach. Someone can enter our system through outreach, shelters, 211, hospitals, law enforcement, DSS, libraries, schools, food pantries, faith-based organizations, and other community partners. Individuals can also call directly to be assessed for housing and connected to Coordinated Entry. This is especially important in suburban and rural communities where homelessness is often less visible and access to transportation is a barrier.
We also do not wait for people to find us. Outreach goes directly into parks, transportation areas, libraries, hospitals, food pantries, and other places where people experiencing homelessness are identified. We receive calls and reports from 311, 211, law enforcement, hospitals, businesses, community organizations, and residents when someone may need help.
We have worked hard to make sure organizations outside of the traditional homeless system know what to do when they encounter someone who is homeless. The CoC lead agency provides training to food pantries, religious institutions, police, and other community organizations so they understand the homeless response system and how to connect someone to us.
We also use our by-name lists, HMIS, Coordinated Entry, and case conferencing to ensure people don't fall through the cracks. We have specific coordination for veterans, youth, survivors of domestic violence, families, and other populations that may need a different approach.
Our expectation is that outreach does more than meet someone's immediate needs. Food, clothing, and basic assistance are important, but we also need to understand what is keeping that person homeless. Teams are educated on housing, treatment, healthcare, benefits, employment, and other resources so each engagement can move toward a solution.
We continually adjust where and how outreach occurs based on what our data, partners, and teams are telling us.

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

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

		Written Agreement
1.	**Child Care (including Child Care and Development Fund)**	Yes
2.	**Early Childhood Providers**	Yes
3.	**Early Head Start**	Yes
4.	**Home Visiting Program (including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)**	Yes
5.	**Head Start**	Yes
6.	**Healthy Start**	Yes
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))	No
2.	School District(s)	No
3.	General Education Development (GED) Program(s)	Yes
4.	Community College(s)	Yes
5.	Technical College(s)	No
6.	Other Post-Secondary Education Provider(s)	Yes

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

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

(limit 2,500 characters)

NY-508's Written Standards require providers serving families with children and youth to inform households experiencing homelessness of their eligibility for educational services and help remove barriers to accessing those services. Providers identify staff responsible for educational coordination and work with the McKinney-Vento liaison in the child's school district.
This process begins as soon as a family enters the homeless system. DSS has designated staff who serve as a first point of contact for McKinney-Vento educational coordination when families are placed in emergency shelter. DSS communicates school and placement information directly to the appropriate school district so transportation, enrollment, and other educational needs can be addressed immediately. This helps prevent a family's shelter placement from unnecessarily disrupting a child's education.
Providers continue that coordination throughout the family's homelessness. Families are informed of their rights under the McKinney-Vento Homeless Assistance Act, including immediate enrollment, remaining in the school of origin when appropriate, transportation, and access to educational services. Providers work with school districts and McKinney-Vento liaisons to address barriers and connect children to preschool, Head Start, special education, tutoring, school meals, and other educational supports. Coordination continues when families move into permanent housing to minimize disruption to the child's education.
NY-508 also recognizes that traditional school may not be the right pathway for every youth. Older youth who are disengaged from school can be connected to alternative education, GED preparation, career and technical education, workforce training, and employment opportunities. The CoC also works with law enforcement, education, and youth-serving partners to create alternative pathways for youth experiencing homelessness who are disconnected from school or involved in the justice system, focusing on reengaging them in education, training, and employment rather than allowing them to become further disconnected from services.
NY-508 has formal partnerships, including an MOU with Erie 1 BOCES, that strengthen access to adult education, career training, and educational resources. Through these policies and partnerships, the program addresses educational needs from the moment a family enters homelessness through the transition back to permanent housing.

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

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

(limit 2,500 characters)

NY-508 coordinates with our foster care and child welfare systems to identify youth exiting public systems who are experiencing homelessness or at risk of homelessness. This includes coordination of identification, referrals, transition/discharge planning, by name list coordination and cross system partnership. The CoC works closely with the foster care system to identify who are expected to exit care within a 90-day period. The CoC determines what services each youth may be eligible for through CoC and YHDP funded organizations. The CoC also coordinates with other community resources, such as the New York State Medicaid 1115, which can provide housing navigation and multiple supportive resources to individuals experiencing homelessness who are enrolled in Medicaid.
Through regular case conferencing, youth who are expected to exit foster care within the 90 day timeframe can be placed on the eligible Youth By-Name List in anticipation of their transition into the homeless response system. This early intervention allows the CoC, child welfare partners, and youth-serving providers to assess housing options, establish community connections and begin engagement before discharge. The CoC coordinates services with youth providers and establishes early engagement with the youth to help ensure a smooth transition from one system to the next. Foster care staff can directly contact the CoC and youth provider before discharging the youth from their care.
Within the Coordinated Entry system, providers also identify youth who have a history of foster care involvement and determine whether they may qualify for the Foster Youth to Independence (FYI) or the Family Unification Program (FUP).
The CoC also partners with Matt Urban’s Empire State Supportive Housing Initiative (ESSHI) Program at Platter Gardens. ESSHI is a New York State program that funds permanent supportive housing and supportive services for vulnerable individuals and families. Matt Urban’s Platter Gardens program provides housing for youth experiencing homelessness and youth transitioning out of foster care and the child welfare system.

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)

Compass House and Pinnacle Community Services are RHY-funded providers within the CoC and are active partners in the homeless response system. The CoC coordinates closely with both providers to ensure that youth experiencing homelessness are connected to appropriate shelter, housing, and supportive services. Both organizations participate in CoC planning and community efforts to address youth homelessness.
Compass House operates an RHY-funded Basic Center Program and Street Outreach Program in Erie County, and Pinnacle Community Services operates the RHY-funded Casey House Basic Center Program in Niagara County. These programs provide critical crisis, shelter, outreach, and supportive services to youth under age 18. Compass House's youth outreach team also coordinates with other street outreach teams, including conducting outreach together. Although outreach teams rarely encounter unsheltered youth under age 18, this collaboration strengthens identification and connections to services for youth and young adults under age 25. When youth are approaching adulthood and may need continued housing assistance, RHY providers coordinate with the CoC and other community partners to support connections to appropriate housing and services for adults.
Both Compass House and Pinnacle Community Services are also Youth Homelessness Demonstration Program (YHDP) providers and have been closely involved in the CoC's implementation of YHDP and broader youth homelessness planning. Their participation helps coordinate the RHY and CoC/YHDP systems and ensures that the experience and expertise of youth-serving providers inform the CoC's strategies, policies, identification of service gaps, and development of housing and service resources for youth and young adults experiencing homelessness.
The CoC also coordinates with RHY providers alongside schools, child welfare, behavioral health providers, shelters, outreach programs, and other youth-serving organizations to strengthen the continuum of services available to youth and support continuity of services as young people transition between systems or age out of youth-specific programs.

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)

Gerard Place CoC Transitional Housing (TH) and Salvation Army Buffalo TH exclusively serves families with children experiencing homelessness. These projects provide transitional housing and supportive services to families with children in accordance with 24 CFR 578.93(b).)

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)

Gerard Place and The Salvation Army's CoC-funded Transitional Housing projects provide supportive services designed to help families increase household income, strengthen employment skills, and improve their ability to obtain and maintain permanent housing.Through individualized case management, staff identify each participant's education, employment, and training needs and connect them to opportunities that can increase their earning potential.
Many of these opportunities are available directly on the Gerard Place campus. Participants can access free GED/NEDP preparation with one-on-one and small-group tutoring, English Language Learner (ELL) classes, and culinary training. Through its partnership with Trocaire College, Gerard Place also offers career-specific training in sterile processing, pharmacy technician, phlebotomy, and EKG. Healthcare Exploration programming helps participants learn about different healthcare careers and identify training and employment pathways that match their interests and abilities.
Gerard Place also works to remove barriers that can prevent parents from participating in education, training, or employment. On-site childcare and before- and after-school care are available so parents can participate in these opportunities and maintain employment while caring for their families.
The Salvation Army's Transitional Housing project similarly connects families to case management and employment supports available. Its Family Resource Center provides career counseling, resume and interview preparation, GED classes, professional-development courses, and certifications.
Together, these projects combine transitional housing with case management, education, job readiness, career-specific training, childcare, and employment connections. These services help parents increase earned income and improve their ability to pay rent, transition to permanent housing, and maintain long-term housing stability.

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)

Gerard Place and The Salvation Army leverage Temporary Assistance for Needy Families (TANF) and a range of other mainstream family service systems to complement their CoC-funded Transitional Housing projects. TANF is one resource within a broader network of supports used to address needs beyond what CoC funding is intended to provide. This allows families to receive additional support related to income, childcare, food, healthcare, employment, and housing stability while CoC resources remain focused on resolving homelessness.
Both projects work with families to identify barriers that may prevent them from obtaining employment, increasing income, or transitioning to permanent housing. When additional support may be needed, staff connect and coordinate families with the appropriate system. DSS determines eligibility for TANF/Family Assistance, SNAP, HEAP, childcare assistance, and other available supports under applicable federal and State requirements.
These resources complement each family's housing plan. Childcare assistance can allow a parent to work or participate in job training; healthcare coverage addresses medical or behavioral health needs; HEAP can reduce energy costs after transition to permanent housing; and DSS employment and training resources can support increased earned income.
Gerard Place has an established connection to the Temporary Assistance system and acts as a Temporary Assistance and SNAP Employment worksite serving Family Assistance and Safety Net Assistance participants. The Salvation Army similarly uses its broader network of family, employment, and community services to connect families to additional resources outside the CoC Program.
Both organizations also help families establish connections to mainstream systems and community resources before leaving Transitional Housing so supports are in place as they move into their own housing. These resources can help families manage rent, utilities, childcare, food, healthcare, and other household needs while continuing to increase earned income.
By combining CoC-funded housing with TANF and other mainstream family-system resources, the projects provide families with a broader network of support designed to strengthen the transition to permanent housing and long-term economic 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)

Gerard Place's CoC Transitional Housing project combines housing assistance with services that support the entire family. Through individualized case management, staff work with parents to identify the needs of both the parent and their children and coordinate those supports while the family is housed. Childcare is available directly through Gerard Place, including on-site babysitting and before- and after-school care. This gives parents the ability to work, attend school or training, keep appointments, and address other family needs while their children have reliable care.
Gerard Place also supports pregnant women and new parents through its Healthy Mom & Baby program, which provides education, supplies, and support during pregnancy and after the birth of a child. When healthcare needs are identified for a parent or child, staff help connect the family to appropriate healthcare providers and community resources.
Parenting and family needs are addressed through ongoing case management, life skills, education, and connections to additional community supports. Parents can also continue their own education through programs available at Gerard Place, including GED/NEDP preparation and English Language Learner classes.
By providing housing while addressing childcare, parenting, healthcare, and education needs, Gerard Place is able to work with the family as a whole. Staff can identify what may be affecting the family's stability and coordinate the supports needed for the family to successfully transition to and maintain permanent housing.

1C-14. Collaboration with Veteran Serving Organizations—Partnership with the U.S. Department of Veterans Affairs or Veteran Serving Organization.

Identify at least one partnership the CoC has with the Department of Veterans Affairs or other Veteran Serving Organizations.

(limit 500 characters)

NY-508 partners with the U.S. Department of Veterans Affairs, SSVF providers and WNY Veterans Housing Coalition to identify, coordinate, and house Veterans experiencing homelessness. VA partners participate in Coordinated Entry and help ensure Veterans are connected to appropriate VA and community resources. Our CoC, also funds WNY Veterans Housing Coalition CoC PSH, providing permanent supportive housing for Veterans experiencing homelessness.

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

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

6.	Fills service gaps for veterans?	Yes

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

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

(limit 500 characters)

NY-508 partners with Child & Family Services, YWCA, Pinnacle Community Services, Community Missions, Family Justice Center, the Erie County Sheriff's Office DV Unit, and the District Attorney's BE SAFE program. Partners provide DV/sexual assault shelter, housing, trafficking services, safety planning, advocacy, and legal/law enforcement support. CFS leads the local DV Coalition, in which the CoC Lead actively participates, strengthening coordination and referrals across systems.

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

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

(limit 500 characters)

NY-508 partners with Peaceprints of WNY, a reentry provider offering pre- and post-release services. Through Project Blue, Peaceprints works with the Erie County Sheriff's Office to provide case management before release and housing coordination, benefits assistance, treatment connections, and employment support after release.

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

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

(limit 500 characters)

NY-508 partners with Erie County Medical Center (ECMC) and Erie County Department of Mental Health SPOA to hold case conferences for individuals experiencing homelessness who are high utilizers of healthcare and have complex medical and behavioral health needs. Together, we coordinate discharge planning, outreach, housing, behavioral health services, and higher levels of care to reduce repeated emergency system 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)

NY-508 partners with the Department for the Aging and providers serving older adults experiencing homelessness. Buffalo City Mission provides medical respite care; People Inc. provides set aside housing units for the elderly experiencing homelessness and supportive services; and Mary Agnes Manor maintains set-aside beds for Medicaid-eligible older adults experiencing homelessness who need assisted living, These partnerships create pathways from homelessness to appropriate care and housing.

1C-19. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Project that Prioritizes Individuals Experiencing Chronic Homelessness.

Identify at least one Rapid Rehousing (RRH) or Permanent Supportive Housing (PSH) project that prioritizes individuals experiencing chronic homelessness.

(limit 500 characters)

NY-508 has multiple Permanent Supportive Housing projects that prioritize individuals and families experiencing chronic homelessness, including Cazenovia Chronically Homeless CoC PSH, Spectrum Chronically Homeless CoC PSH, and BestSelf Chronically Homeless CoC PSH. These projects receive referrals through Coordinated Entry, where chronically homeless households are the highest priority for PSH in accordance with the CoC's Written Standards.

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)

The PSH projects identified in 1C-19 provide behavioral healthcare on-site and can bring services directly to an individual's apartment. BestSelf Behavioral Health, Spectrum Health & Human Services, and Cazenovia Recovery Systems all have extensive experience serving individuals with mental health, substance use, and co-occurring disorders.
Rather than requiring an individual to travel to an office for every service, behavioral health professionals can meet with residents where they live. On-site staff also work directly with residents to identify changes in behavior or functioning, support treatment and medication needs, provide recovery and crisis support, and recognize when additional intervention may be necessary.
One of the strengths of these projects is the knowledge and larger service network each agency brings to the housing program. These are not agencies that only provide housing. Each organization provides a broader range of behavioral health, substance use, clinical, and community-based services. Because of this, staff are able to recognize when someone's needs have increased and quickly navigate the individual to additional treatment or a higher level of care within their own agency or through an established community partner.
This is especially important for individuals who have experienced chronic homelessness. Many enter PSH with significant mental health, substance use, medical, and other needs and may have a history of not staying connected to traditional treatment. Bringing behavioral healthcare directly to the individual's apartment removes a barrier to care, while the larger network behind each project allows the provider to increase services when the individual's needs change.
This model allows behavioral healthcare to follow the individual instead of expecting the individual to navigate multiple systems on their own.

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)

Our CoC's Written Standards establish expectations for ongoing case management and reassessment across CoC-funded permanent housing. The Standards require participants to meet with a case manager no less than monthly and require programs to reassess assistance and supportive services needed to meet participant needs. Consistent with this policy, the three PSH providers identified in 1C-19 continually assess whether participants' needs can be adequately addressed through PSH and available community-based services or whether a higher level of care may be necessary.
Assessment begins through Coordinated Entry before referral to PSH to support appropriate project matching and continues throughout program participation through regular case management and service planning. When existing interventions are unsuccessful, a participant's needs increase, or staff identify concerns that may exceed what can appropriately be addressed within PSH, providers reassess the participant's needs and determine whether additional supports or assessment for a higher level of care may be appropriate.
Indicators that trigger further assessment may include repeated hospitalizations or emergency-room use; significant physical or cognitive decline; inability to safely complete activities of daily living or manage medications; escalating behavioral health or substance use needs; increased safety concerns; or needs that can no longer be adequately addressed through PSH and community-based services.
When these indicators are identified, PSH staff coordinate referral to the appropriate qualified medical, behavioral health, substance use, or other professional for assessment. Depending on the identified need, this may include evaluation for assisted living, skilled nursing, residential treatment, or another appropriate level of care.
When a higher level of care is recommended, staff coordinate with the participant, healthcare and treatment providers, benefits systems, family or identified supports, and other partners to facilitate the transition. Staff assist with referrals, applications, documentation, benefits, transportation, and transition planning and follow the referral through placement. Assessments, recommendations, referrals, follow-up, and outcomes are documented in the participant's record.

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)

Consistent with HUD's Moving On strategy and CoC policy, all PSH providers, including the 3 programs listed in 1c-19, are required to maintain a Moving On policy that includes assessing program participants' interest in and readiness to move on from PSH to unsubsidized or other permanent housing. The CoC also incorporates Moving On outcomes into its annual project evaluation, awarding points to projects that successfully support participants in moving to unsubsidized permanent housing. The CoC shares HUD's Moving On guidance and provides recommended assessment tools that projects may adopt or incorporate into their own policies and procedures.

For NY-508, the readiness conversation begins at intake. This does not mean that a participant is expected to move on from PSH. Rather, the initial assessment helps establish where the participant is when they enter the program, including their housing stability, income and benefits, health and healthcare needs, connection to supports, and level of service need. This gives the participant and provider a starting point that can be revisited as needs, stability, and circumstances change.

Readiness is reassessed as part of the annual assessment and every six to twelve months thereafter, or sooner if the participant expresses an interest in moving on or their circumstances change.

HAWNY has worked directly with PSH providers on this process and has recommended the Life After Supportive Housing (LASH) Readiness Self-Assessment Tool as one option providers may incorporate into their policies and regular service planning. The LASH allows participants to assess their own readiness in six areas: rent payment, utility bills, income, community living, community services and supports, and housing stability.

When a participant is interested in and assessed as ready to move on, staff work with the participant to determine whether unsubsidized housing or another permanent housing option is appropriate and to ensure that services and resources needed for continued housing stability are in place. Participants who continue to need PSH remain in PSH.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	08/05/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

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

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

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

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

(limit 2,500 characters)

The CoC Funding Guide establishes criteria for identifying renewal projects that may be candidates for reallocation, including unspent funds, low performance, program design that does not align with current HUD priorities or best practices, reduced community need, compliance concerns, and projects that voluntarily reduce or relinquish funding.
All renewal projects submit a local application, budget, financial audit, and HUD monitoring/audit information. Projects first undergo a threshold review for Coordinated Entry participation, HMIS/comparable database participation, applicable service participation requirements, and match. Projects are then scored using objective performance data from HMIS/comparable databases. Depending on project type, measures include exits to or retention in permanent housing, movement to unsubsidized permanent housing, time to housing, returns to homelessness, increases in employment income, service to higher-need populations, and HMIS data quality. The rubric also includes a community-need factor.An independent Project Selection Committee reviews project applications and performance scores and makes reallocation decisions based on community need, the quality of proposed new projects, and renewal project performance.
Yes. The CoC identified lower-performing and/or less-needed projects through its FY2026 review process.
Yes. During the FY2026 local competition, the CoC reallocated more than $9 million to restructure projects, funding new projects to better align the local portfolio with current HUD requirements and priorities.
Not applicable. The CoC reallocated projects during the FY2026 local competition.

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

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

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

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

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

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

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

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

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

2A-3.	PIT Count–Methodology Change.	

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

(limit 2,500 characters)

There is no Methodology or data quality change in this year's PIT count. The changes we see are due to this year, the CoC placed greater emphasis on offering individuals experiencing unsheltered homelessness transportation to available shelter, particularly seasonal cold-weather shelter. Combined with increased year-round shelter capacity, this contributed to fewer individuals remaining unsheltered on the night of the PIT Count and a corresponding increase in the sheltered population. This reflects a change in system response and shelter availability rather than a change in PIT methodology.

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)

Unsheltered homelessness in the CoC is generally dispersed across small outdoor locations rather than large encampments. For purposes of this NOFO, the CoC defines an encampment as a known outdoor location where three or more individuals reside together. No identified encampment exceeded 15 individuals. Locations with one or two individuals are tracked and served by Street Outreach but are not classified as encampments for this application. During the evaluation period, the CoC reduced identified encampments from 35 to 11 through strengthened coordination, systematic tracking, and targeted outreach. The CoC established a monthly coordination meeting bringing together Street Outreach providers, local law enforcement, NFTA Police, Department of Health outreach staff, and other community partners to review known locations, coordinate engagement, identify barriers, and determine next steps.
The CoC created a shared Google Map that tracks known unsheltered locations, estimated number of people, outreach engagement, and whether sites are active, resolved, or inactive, without including PII. Client-level information, assessments, and services are maintained in HMIS. Information from 311, law enforcement, outreach teams, partners, and residents is used to identify and add new locations.
For larger encampments, the CoC coordinates outreach providers to conduct joint outreach and surveys of the location, allowing teams to identify everyone residing at the site, understand individual needs and barriers, complete or update Coordinated Entry assessments, and divide follow-up responsibilities among providers. Outreach teams then conduct repeated engagement and case conferencing rather than relying on one-time contacts. Information from 311, law enforcement, outreach teams, community partners, and residents is also used to identify new locations so they can be added to the shared mapping and outreach process.
The CoC focuses on reducing the number of people remaining unsheltered rather than moving people between outdoor locations. During 2025, 24 encampments involving 119 individuals were resolved. Street Outreach successful exits increased from 37.27% in FY2023 and 43.04% in FY2024 to 57.18% in FY2025, demonstrating improved connections to temporary, institutional, and permanent destinations.

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

1. Enter the estimated number of encampments in the beginning of your evaluation period.	35
2. Enter the reduction in the number of encampments during your evaluation period.	24

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.	165

2. Enter the reduction in the number of people in encampments during your evaluation period.	119

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 housing instability earlier, expanding prevention resources, and targeting interventions based on local data. Eviction accounts for 34% of reported primary causes of homelessness. Among 4,966 people experiencing homelessness for the first time, 1,364 were children and 665 were age 55 or older. Only 129 (2.6%) were veterans, indicating that substantial federal resources and coordinated services dedicated to preventing and ending veteran homelessness are working effectively in our community. Additionally, 1,926 people reported a disabling condition, with mental health disorders the most frequently reported condition.

ESG recipients have increased homelessness prevention funding, while local Departments of Social Services provide rental arrears and emergency assistance to help households with children retain housing. Medicaid 1115 Waiver housing services further expand prevention resources for eligible Medicaid members through rent and utility assistance, housing navigation, pre-tenancy, and tenancy-sustaining services.

The CoC works closely with the Erie County Department of Mental Health (ECDMH), which provides service coordination and housing resources for people with mental health needs to prevent homelessness and support housing stability. The CoC is also strengthening coordination with healthcare and behavioral health providers to identify housing instability and connect people to housing, treatment, benefits, and other supports before a health or behavioral health crisis results in homelessness.

Coordinated Entry provides housing search and navigation to help households identify alternative housing options and resolve housing crises. Workforce and employment partners connect households with employment, training, and income-building opportunities to improve long-term stability.

The CoC is expanding partnerships with the Department of Aging to identify and assist older adults experiencing housing instability and is establishing a landlord engagement group to increase available housing options and address screening and leasing barriers, including credit and rental-history requirements. Together, these strategies target both immediate housing crises and the financial, health, and housing barriers contributing to first-time homelessness.

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 uses HMIS, System Performance Measures, and system-level analysis to identify populations experiencing the longest periods of homelessness and target strategies to reduce barriers to permanent housing. Current data indicate that older adults experience some of the longest stays in the homeless response system. Families, particularly households with multiple children, also experience longer stays. Both populations often face housing and service needs that cannot be fully addressed through resources available within the crisis response system alone.

The CoC is increasing housing resources targeted to families through CoC-funded programs and continues to prioritize households with longer histories of homelessness for available permanent housing resources through Coordinated Entry. The CoC is also strengthening connections to resources outside the CoC Program. This includes partnering with State-funded Empire State Supportive Housing Initiative (ESSHI) projects serving older adults and utilizing newly available Medicaid 1115 Waiver housing services for eligible households, including housing navigation, rental assistance, pre-tenancy services, and tenancy-sustaining supports.

Housing navigation is provided through Coordinated Entry and partner agencies to help households identify available units and overcome barriers to lease-up. The CoC is also developing a landlord engagement group to expand landlord participation, identify available units, and address screening and leasing barriers that contribute to longer shelter stays. DSS resources are used when appropriate for security deposits, moving costs, rental and utility arrears, storage, and other assistance necessary to secure or maintain housing.

Coordinated Entry uses HMIS and documented homeless history to identify households experiencing extended periods of homelessness. The By-Name List is reviewed regularly, and CE staff, shelters, outreach teams, housing providers, and other partners case conference households with significant barriers, identify appropriate housing resources, and coordinate referrals as openings become available.

Through targeted resources for populations experiencing the longest stays, expanded mainstream and supportive housing partnerships, housing navigation, landlord engagement, and individualized case conferencing, the CoC will reduce delays in moving households from homelessness to permanent housing.

2A-7.	Successful Permanent Housing Placement–Exits to Unsubsidized Housing.	

Based on HMIS data, what percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing?	47.50%

Describe how you calculated the data for this response.

(limit 2,500 characters)

During the 12-month reporting period of October 1, 2024 through September 30, 2025, a total of 644 program participants exited TH, RRH, and PSH projects within the CoC. Of these 644 total exits, 306 exited to one of the four unsubsidized housing destinations identified by HUD under HMIS Data Element 3.12 (Exit Destination): Staying or living with family, permanent tenure; Staying or living with friends, permanent tenure; Rental by client, no ongoing housing subsidy; or Owned by client, no ongoing housing subsidy. The CoC calculated the percentage by dividing the 306 exits to these destinations by the universe of 644 TH/RRH/PSH exits. This equals 47.5%.

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.	01/22/2026

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	1,763	43	1,806	95.30%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	262	40	345	87.50%
4. Rapid Re-Housing (RRH) beds	378	44	422	100.00%
5. Permanent Supportive Housing (PSH) beds	1,410	0	1,410	100.00%
6. Other Permanent Housing (OPH) beds	124	0	124	100.00%

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)

All projects meet the 84.99 thresholds. Question not applicable.

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

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

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

4A. Attachments Screen For All Application Questions

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

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

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

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

Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes		
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	List of coc progr...	09/28/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes		
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	Local Competition...	09/24/2026

06. 1D-2c. Local Competition Selection Results	Yes	Local competition...	09/21/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	FY 2026 HDX Compe...	09/21/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No		
09. 3A-2a. Project List for Other Federal Statutes	No		
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No		
11. Other	No		

Attachment Details

Document Description:

Attachment Details

Document Description: List of coc program projects and number of units that require substance treatment

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Local Competition Scoring Tool

Attachment Details

Document Description: Local competition ranking and result

Attachment Details

Document Description: FY 2026 HDX Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/25/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/29/2026
1C. Coordination and Engagement	09/29/2026
1D. Project Review/Ranking	09/29/2026
2A. HMIS Implementation	09/28/2026
3A. Policy Initiatives	09/28/2026
4A. Attachments Screen	Please Complete
Submission Summary	No Input Required

2026 CoC and YHDP Renewal Application Scoring Rubric

A. Threshold Review

1. Coordinated Entry Participation
   ☐ Pass ☐ Fail
2. HMIS Participation (or Comparable Database for Victim Service Providers)
   ☐ Pass ☐ Fail
3. Service Participation Requirement (if applicable)
   ☐ Pass ☐ Fail ☐ N/A
4. Match Requirement Met
   ☐ Pass ☐ Fail

B.Scoring Rubric

Project Type	Rating Factor	Data Source	Measure	Total Points
Exit to Permanent Housing				
CoC RRH	Percent of clients who move to permanent housing	APR: 23c "Permanent Destinations Subtotal"	≥90% = 10 85% - <90% = 8 80% - <85% = 5	10
CoC PSH	Percent of clients who remain in or move to permanent housing	APR: 23c "Permanent Destinations Subtotal" + 5a "Number of Stayers"	≥96% = 10 93% - <96% = 5 90% - <93% = 2	
YHDP RRH or Joint RRH-TH	Percent of clients who move to permanent housing	APR: 23c "Permanent Destinations Subtotal"	≥60% = 7.52 55% - <60% = 3.76 50% - <55% = 2.5	7.52
YHDP SSO	Percent of clients who move to permanent housing	APR: 23c "Permanent Destinations Subtotal"	≥96% = 7.52 93% - <96% = 3.76 90% - <93% = 2.5	

CoC RRH	Percent of clients who move to unsubsidized permanent housing	APR: 23c "Rental by client, no ongoing housing subsidy" + 23c "Owned by client, no ongoing housing subsidy"	≥70% = 10 50% - <70% = 5	10
CoC PSH	Percent of clients who move to unsubsidized permanent housing	APR: 23c "Rental by client, no ongoing housing subsidy" + 23c "Owned by client, no ongoing housing subsidy"	≥40% = 10 25% - <40% = 5	
Quickly Housing Clients				
CoC RRH and PSH	Average time to housing based on time between project start date and Housing Move-in Date	APR: 22c "Average Length of time to housing"	≤35 days = 10 >35 – 60 days = 8	10
Returns to Homelessness				
CoC RRH and PSH	Percent of clients who return to homelessness within 6 months after exiting to permanent housing	Calculated by HMIS Staff using project's HMIS Data	≤9% = 15 >9% - 15% = 5	15
YHDP RRH or Joint RRH-TH and SSO	Percent of clients who return to homelessness within 6 months after exiting to permanent housing	Calculated by HMIS Staff using project's HMIS Data	≤5% = 7.52	7.52
Adults who Increased Employment Income				

CoC RRH and PSH	Percent of adult leavers who increased their income from employment (Earned Income)	APR: 19a2 "Percent of Persons who Accomplished this Measure"	≥30% = 10 15% - <30% = 5	10
CoC RRH and PSH	Percent of adult stayers who increased their income from employment (Earned Income)	APR: 19a1 "Percent of Persons who Accomplished this Measure"	≥20% = 10 15% - <20% = 5	10
Improved Health and Social Wellbeing				
YHDP RRH or Joint RRH-TH and SSO	Percent of HoH leavers whose health improved	Calculated by HMIS Staff using project's HMIS Data	≥13% = 16.47 10% - <13% = 10.5	16.47
YHDP RRH or Joint RRH-TH and SSO	Percent of HoH leavers with a permanent connection	Calculated by HMIS Staff using project's HMIS Data	≥60% = 15.05 50% - <60% = 12.6 40% - <50% = 10.5	15.05
YHDP RRH or Joint RRH-TH and SSO	Percent of HoH enrolled in school	Calculated by HMIS Staff using project's HMIS Data	≥18% = 14 14% - <18% = 9.89	14 (Whichever measure earns the higher score is used)
	Percent of HoH employed	Calculated by HMIS Staff using project's HMIS Data	≥40% = 14 30% - <40% = 10.5 25% - <30% = 7	
Serving Higher Need Clients				
CoC RRH	Percent of clients experiencing 1+ Disability	APR: 13b2 and 13c2 "1 Condition," "2 Conditions," "3+ Conditions," and "Condition Unknown"	≥40% = 5	5
CoC PSH	Percent of clients experiencing 2+ Disabilities	APR: 13b2 and 13c2 "2 Conditions," "3+ Conditions," and "Condition Unknown"	≥80% = 5	

YHDP RRH or Joint RRH-TH and SSO	Percent of clients experiencing 1+ Disability	APR: 13b2 and 13c2 "1 Condition," "2 Conditions," "3+ Conditions," and "Condition Unknown"	≥50% = 15	15
CoC RRH and PSH	Percent of clients experiencing a Physical Disability	APR: 13b1 and 13c1 "Physical Disability"	≥25% = 5	5
CoC RRH and PSH	Percent of clients aged 62+	Calculated by HMIS Staff using project's HMIS Data	≥25% = 10	10
Operating at Capacity				
YHDP RRH or Joint RRH-TH and SSO	Percentage of project's contracted client capacity that has been served	Calculated by HMIS Staff using project's HMIS Data	≥85% = 9.44 70% - <85% = 8.4 60% - <70% = 7	9.44
HMIS Data Quality				
All Projects	Personally Identifiable Information	APR: 6a "Overall Score"	≤5% = 2 >5% - 10% = 1	2
All Projects	Universal Data Elements	APR: 6b "Veteran Status", 6b "Project Start Date", 6b "Relationship to Head of Household", 6b "Enrollment CoC", and 6b "Disabling Condition"	≤5% = 2 >5% - 10% = 1	2
All Projects	Destination	APR: 6c "Destination"	≤5% = 2	2
All Projects	Income	APR: 6c "Income and Sources at Start", 6c "Income and Sources at Annual Assessment" and 6c "Income and Sources at Exit"	≤5% = 2	2

All Projects	Chronic Homelessness	APR: 6d row for Project Type	≤5% = 2	2
All Projects	Timeliness	APR: 6e all fields	≥50% in 0-3 days = 5 ≥50% in 0-6 days = 3	5
Total Points				**100**
Bonus:Meeting Community Need				**30**

NY-508 CoC – NEW PROJECT SCORING SHEET

A. HUD Threshold Review and Eligibility Determination

Prior to scoring, all applications will be reviewed for compliance with HUD threshold requirements, eligibility requirements, and local competition requirements. Applications that fail any threshold requirement may be determined ineligible for funding consideration.

Threshold Review

1. Eligible Applicant Entity
   ☐ Pass ☐ Fail
2. Coordinated Entry Participation
   ☐ Pass ☐ Fail
3. HMIS Participation (or Comparable Database for Victim Service Providers)
   ☐ Pass ☐ Fail
4. Racial Non-Discrimination
   ☐ Pass ☐ Fail
5. Federal Compliance Status
   ☐ Pass ☐ Fail
6. Safe Consumption Site and Drug Enablement Restrictions
   ☐ Pass ☐ Fail
7. Service Participation Requirement (if applicable)
   ☐ Pass ☐ Fail ☐ N/A
8. Timely Implementation Capacity
   ☐ Pass ☐ Fail
9. Conflict-Free Administration
   ☐ Pass ☐ Fail
10. Match Requirement Met
    ☐ Pass ☐ Fail
11. HUD Program Eligibility Requirements
    ☐ Pass ☐ Fail

B New Project Score (Total: 100)

Project Name :_____

Evaluator Name: _____

Category	Points	Project Score
Applicant Experience and Past Performance	25	
Project Design & HUD Priority Alignment (Housing Stability, Self-Sufficiency, & Participant Outcomes)	20	
Financial Stability & Compliance Capacity	10	
Cost Effectiveness	10	
Experience Serving Proposed Population	5	
Experience Managing Federal/Complex Grants	5	
Organizational Capacity and Staffing	5	
Community Need & System Impact	10	
Regional Fair Share / Geographic Priority	10	
Total	**100**	

1

2

Project Name	Total Pts	Rank	Amount Requested from HUD	Region	Funding Type	Reallocated Funds	Status
Cazenovia Chronically Homeless CoC I	97	1	$1,234,129	Erie	Renewal	$0	Accepted
WNY Veterans Housing Coalition CoC	96	2	$565,872	Erie	Renewal	$0	Accepted
Matt Urban PSH	95	3	$688,409	Erie	Reduced renewal	-$458,940	Reduced reallocated
Spectrum Chronically Homeless CoC F	94	4	$678,605	Erie	Reduced renewal	-$119,754	Reduced reallocated
Hispanos Unidos CoC RRH I/II	93	5	$671,484	Erie	Renewal	$0	Accepted
BestSelf Harambe House CoC PSH	90	6	$575,479	Erie	Renewal	$0	Accepted
Cazenovia Niagara CoC PSH	90	6	$192,616	Niagara	Renewal	$0	Accepted
DePaul CoC III PSH	90	6	$568,462	Erie	Renewal	$0	Accepted
Matt Urban Hope Gardens CoC PSH	90	6	$664,685	Erie	Renewal	$0	Accepted
ECDMH CoC II PSH	86	10	$6,302,793	Erie	Reduced renewal	-$389,664	Reduced reallocated
Compass House CoC Joint RRH	83	11	$372,165	Erie	Renewal	$0	Accepted
Spectrum Wyoming County Dedicatec	83	11	$137,633	Genesee Orleans,Wyom	Renewal	$0	Accepted
ILGR CoC RRH	81	13	$400,000	Genesee Orleans,Wyom	Reduced renewal	-$505,687	Reduced reallocated
CMI CoC RRH	80	14	$378,179	Niagara	Reduced renewal	-$66,738	Reduced reallocated
BestSelf Chronically Homeless CoC PS	77	15	$640,407	Erie	Renewal	$0	Accepted
HAWNY NY-508 CE		16	$418,182	All	Renewal	$0	Accepted
NY508 HMIS		16	$227,840	All	Renewal	$0	Accepted
CFS DV CE		18	$80,115	Erie	Reduced renewal	-$80,115	Reduced reallocated
Gerard Place CoC TH	76	19	$381,821	Erie	New Project-Reallocation Dollar	$381,821	Accepted
CFS DV Bonus 2026	76	20	$617,743	Erie	DV bonus		Accepted
Compass House YHDP TH	76	21	$676,808	Erie	New Project-YHDP Replacement Project	$676,808	Accepted
TSI- TH	76	22	$441,085	Erie	New Project-Reallocation Dollar	$441,085	Accepted
YWCA My Sister's Sanctuary	76	23	$595,213	Genesee Orleans,Wyom	New Project-Reallocation DV	$595,213	Accepted
Salvation Army Buffalo TH	76	24	$602,540	Erie	New Project-Reallocation Dollar	$602,540	Accepted
Hispanos Unidos CoC TH	75	25	$388,967	Erie	New Project-Reallocation DV	$388,967	Accepted
Jewish Family services TH	75	25	$607,612	Erie	New Project-Reallocation Dollar	$607,612	Accepted
Gerard Place Scattered site TH	75	27	$629,529	Erie	New Project-Reallocation Dollar	$629,529	Accepted
BestSelf YHDP TH	75	28	$654,294	Erie	New Project-YHDP Replacement Project	$654,294	Accepted
City Mission TH	74	29	$573,093	Erie	CoC bonus		Accepted
Caz TH	74	30	$1,355,925	Erie	CoC Bonus		Accepted
Harvest House TH	73	31	$599,381	Erie	New Project-Reallocation Dollar	$599,381	Accepted
CMI YHDP TH	72	32	$533,674	Niagara	New Project-YHDP Replacement Project	$533,674	Accepted
Matt Urban TH	68	33	$816,178	Erie	CoC bonus		Accepted
Pinnacle Community Services YHDP	66	34	$211,133	Niagara	New Project-YHDP Replacement Project	$211,133	Accepted
Plymouth Crossroads	65	35	$220,128	Erie	CoC bonus	$0	Accepted
Allign WNY	63	36	$487,500	Niagara	CoC bonus	$0	Accepted
Do For Self Foundation	52		$0	Erie		$0	Rejected
Empowerment Temple Ministries	51		$0	Erie		$0	Rejected
Project withdraw #1			$0	Erie		-$996,161	Fully Reallocated

Project withdraw #2			$0	Erie		-$360,954	Fully Reallocated
Project withdraw #3			$0	Erie		-$564,636	Fully Reallocated
Gerard Place CoC PSH			$0	Erie		-$381,821	Fully Reallocated
Compass House YHDP TH-RRH			$0	Erie		-$676,808	Fully Reallocated
TSI- PSH			$0	Erie		-$441,085	Fully Reallocated
YWCA My Sister's Sanctuary RRH			$0	Genesee Orleans,Wyoming		-$595,213	Fully Reallocated
Salvation Army Buffalo RRH			$0	Erie		-$602,540	Fully Reallocated
Hispanos Unidos CoC DV RRH			$0	Erie		-$388,967	Fully Reallocated
Jewish Family services RRH			$0	Erie		-$607,612	Fully Reallocated
Gerard Place RRH			$0	Erie		-$629,529	Fully Reallocated
BestSelf Family Engagement Team			$0	Erie		-$332,683	Fully Reallocated
BestSelf Overnight Drop-In for TAY			$0	Erie		-$321,611	Fully Reallocated
Harvest House RRH			$0	Erie		-$599,381	Fully Reallocated
CMI YHDP TH-RRH			$0	Niagara		-$533,674	Fully Reallocated
Pinnacle Community Services YHDP			$0	Niagara		-$211,133	Fully Reallocated
CoC planning grant			$1,354,239			$0	Not Ranked
	Max DV bonus	$5,000,000		Total Request:	$26,543,919		
	Max CoC bonus	$4,062,717		DV bonus request:	$617,743		
	Reallocated amo	-$9,864,704		CoC bonus Request:	$3,452,824		
	Tier 1:	$14,797,056		Reallocation Request:	$6,322,057		
				Renewal request:	$14,797,056		