

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: IL-513 - Springfield/Sangamon County CoC

1A-2. Collaborative Applicant Name: Heartland Housed

1A-3. CoC Designation: CA

1A-4. HMIS Lead: MERCY Communities

1B. Coordination and Engagement–Accountable Structure and Participation

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

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- Frequently Asked Questions

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

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

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

	Entity	Participated in CoC Meetings	Number of Board Members
1.	Affordable Housing Developer(s)	Yes	1
2.	CDBG/HOME/ESG Entitlement Jurisdiction(s)	Yes	2
3.	Certified Community Behavioral Health Clinic (CCBHC)	Nonexistent	
4.	Community Mental Health Center (CMHC)	Yes	1
5.	Disability Advocate(s)	Yes	1
6.	Disability Service Organization(s)	Yes	1
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	3
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	0
9.	Faith-based Organization(s)	Yes	4
10.	Homeless or Formerly Homeless Person(s)	Yes	3
11.	Hospital(s)	Yes	3
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	0
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Nonexistent	
14.	Law Enforcement	Yes	1
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	0
16.	Local Government Staff/Official(s)	Yes	2

17.	State Government Staff/Official(s)	Yes	0
18.	State or Local Elected Public Official(s)	Yes	3
19.	Local Jail(s)	Yes	0
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	1
23.	Other homeless subpopulation advocate(s)	Yes	0
24.	Other nonprofit homeless assistance provider(s)	Yes	5
25.	Other social service provider(s)	Yes	4
26.	Public Housing Agencies	Yes	2
27.	Recovery Housing or Sober Living Provider(s)	Yes	0
28.	School Administrators/Homeless Liaison(s)	Yes	1
29.	School District(s)	Yes	0
30.	Street Outreach Team(s)	Yes	1
31.	Substance Abuse Advocate(s)	Yes	0
32.	Substance Abuse Service Organization(s)	Yes	0
33.	Universities	Yes	0
34.	Veteran Serving Organization(s)	Yes	1
35.	Agencies Serving Survivors of Human Trafficking	Yes	0
36.	Victim Service Provider(s)	Yes	1
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	1
42.	Youth Homeless Organization(s)	Yes	1
43.	Youth Service Provider(s)	Yes	1
44.	Other Homeless Assistance Provider(s)	Yes	1
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	0
	Other: (limit 50 characters)		
46.			
47.			

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

(limit 2,500 characters)

HCoC extends public invitations a minimum of six times a year through a variety of mediums to solicit new members to join the CoC. The front page of the HCoC website instructs any person or organization on how to become a part of the CoC Membership and new sign-ups for the HCoC newsletter receive a follow-up inviting them to become a Member. Public invitations were extended through the CoC Facebook page and as a part of public presentations our Continuum staff gave at Sangamon County and City of Springfield government meetings, Rotary, Kiwanis and Greater Springfield Interfaith Association meetings, Westminster Presbyterian Church, Capital Township, and neighborhood associations. The Community Education Task Group encouraged community members to take an online, on-demand community ambassador training that has been completed by 190 Community members and educates on our strategy, programs, and ends with an opportunity to join our CoC Membership. Community summits, focus groups, and lived experience listening sessions connected to our community wide strategic planning process also shared information about joining the CoC Membership. Quarterly updates are shared with local government, stakeholders, media and the community which directs people on how to partner in the HCoC's work and join the CoC Membership.

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

(limit 2,500 characters)

Heartland Continuum of Care (HCoC) utilizes a number of approaches to maintain a transparent, inclusive process for soliciting and considering community input regarding homelessness. Heartland Housed, the CoC lead agency, coordinates engagement and incorporates feedback into strategic planning, policies, funding priorities, and service improvements.

HCoC holds public bi-monthly CoC meetings with structured opportunities for public comment, stakeholder updates, and discussion of homelessness trends, system performance, and priorities. The CoC uses focus groups, community meetings, and the lived experience advisory board to gather feedback from people impacted by homelessness. HCoC staff participate in and present at neighborhood association, City Council, Township, County Board, Chamber of Commerce, Faith Community and other CIVIC meetings to share information and solicit community perspectives. Heartland Housed staff and board members also present at Rotary Club meetings, faith community gatherings, and other community events.

HCoC uses its website, Facebook page, email newsletter, and the HCoC Connect Phone App to expand community engagement. The app allows community members to easily share concerns related to homelessness and request a response from our Street Outreach team. Our email newsletter reaches approximately 460 recipients and provides opportunities for questions and feedback.

Through these avenues, HCoC receives input from people with lived experience, service provider staff and agencies, behavioral health providers, government agencies, elected officials, faith communities, businesses, philanthropic organizations, advocates, neighborhood groups, and interested residents. Each of these stakeholders brings a unique perspective on service gaps, behavioral health needs, community resources and progress that informs system improvement and strategy.

HCoC considers community feedback alongside system data to inform strategic planning, policies, funding priorities, and service improvements. Community feedback has elevated unsheltered homelessness, street outreach, and emergency shelter availability as priority areas and led to growth in street outreach staff, development of street medicine, and the establishment of a complex care initiative.

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

(limit 2,500 characters)

HCoC notified the public that it is accepting project application proposals by posting on the HCoC website and facebook page, emailing all CoC email subscribers, and ANNOUNCING the local competition at the CoC Membership meetings prior to competition start. HCoC invited organizations who have not previously received funding through the CoC program to apply through announcements and posts about the competition.

HCoC hosted a public competition TA webinar to help new applicants with the NOFO process. The TA webinar walked through a step-by-step process for completing and submitting project applications and included information on the local competition policy. Video of the TA webinar was added to CoC website for potential applicants to watch on demand. In all communications, questions were welcomed so CoC staff could provide individualized assistance for first time applicant organizations. A question form was added to the Heartland website. Heartland Housed staff provided TA for three new organizations who were exploring HUD funding for the first time this year. One new faith based organization applied for funding during this competition and the project is included in the hcoc recommended list of projects.

HCoC communicated about project applications submission through the HCoC website, instructions included in the local application and through CoC competition TA webinar. The process involved organizations completing an online project application for all new and renewal projects the organization desired to apply for. Additionally, organizations provided program budgets and an APR or other data needed for the scoring process by email to CoC staff.

All HCoC Competition communication included links to HCoC Local Competition Policy, Appeal Process, and Rating and Ranking Scorecards. Competition information was posted on the HCoC website, Facebook posts, and CoC emails which are also posted publicly on the HCoC Website. HCOC scored and ranked renewal and new projects based on objective factors about agency capacity, system performance, and community need. The Rating and Ranking Committee included five individuals with diverse backgrounds. The Rating & Ranking Committee presented a recommended ranked list to the HCoC Board for approval per the local competition policy. All organizations were informed about the competition results and provided information about next steps. No appeals were filed in connection to this year's competition results.

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

(limit 2,500 characters)

The Heartland Continuum of Care (HCoC) is implementing a comprehensive strategy to reduce chronic homelessness by addressing gaps in supportive housing (SH), mental health services, and substance use treatment. Heartland HOUSED, the CoC lead agency, will oversee implementation.

THE GAP: HCoC's by-name list identifies 101 individuals experiencing chronic homelessness. By-name data and stakeholder feedback from strategic planning focus groups highlight the need for additional SH, including rental subsidies and case management, and improved access to mental health and substance use treatment. Limited housing capacity and gaps in integrated services impede progress toward housing stability.

STRATEGIES:

- Expand SH: Partner with housing providers to increase opportunities through the Heartland Flexible Housing Pool (HFHP) and Frequent User System Engagement (FUSE) program, prioritizing individuals experiencing chronic homelessness with the highest needs.
- Strengthen Behavioral Health Connections: Coordinate with mental health and substance use treatment providers to deliver accessible, person-centered services and ensure continuity from outreach through housing stability.
- Increase Income and Promote Move On: Help PSH residents access employment, benefits, and income supports. Support eligible residents in transitioning to independent housing, creating additional PSH openings.

PERFORMANCE MEASURES:

- Chronic Homelessness Reduction: Reduce the by-name list from 101 to 76 or fewer individuals (25% decrease) within 12 months.
- Income Growth: Increase by 25% within 12 months the percentage of PSH stayers and leavers with increased total income to support Move On readiness.
- Heartland Housed will track progress through by-name list data, housing placements, and provider reporting to review and share quarterly.

TIMELINES:

- Q1 2027: Launch FUSE to serve 20 chronically homeless individuals with housing and support. Host an Income Maximization Summit to promote income growth.
- Q2 2027: Serve 15 chronically homeless individuals through the HFHP with housing and support.
- Q3 & Q4 2027: Supportive housing providers will assist 10 PSH residents in transitioning to independent housing through Move On.

FUNDING SOURCES:

- HUD and State of Illinois funding will support supportive housing programs and housing exits.
- HFHP is funded by local faith communities, philanthropy, and government partners.
- FUSE is funded by local hospitals.

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

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

1C. Coordination and Engagement

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

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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?	33%

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

(limit 2,500 characters)

Not applicable, IL-513 is not a rural CoC.

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

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

(limit 2,500 characters)

Heartland Continuum of Care (HCoC) partners with behavioral health providers (SIU, Family Guidance Center and Alpharus), Community Mental Health Centers (Memorial Behavioral Health (MBH) and Envision Unlimited), Federally Qualified Health Centers (SIU School of Medicine and Central Counties Health Centers (CCHC)), hospitals, housing providers, and community organizations to connect individuals experiencing homelessness with primary care, outpatient mental health and substance use treatment, crisis intervention, medication management, and recovery supports.

INITIAL CONNECTION TO SERVICES: HCoC partners with SIU's street medicine team to build trust and connect unsheltered individuals to primary care and medication management. CCHC provides care in a clinic located within Helping Hands, HCoC's largest emergency shelter. MBH's PATH staff work with street outreach teams and emergency shelters to identify individuals with serious mental illness (SMI) and connect them to outpatient services and psychiatric care.

OUTPATIENT MENTAL HEALTH TREATMENT: MBH provides counseling, case management, crisis stabilization, and community-based crisis response. Envision Unlimited provides mental health assessment, treatment, care coordination, and support for individuals with serious mental illness. SIU psychiatry services coordinate with MBH and local hospitals to support ongoing care.

SUICIDE PREVENTION AND CRISIS RESPONSE: MBH's Mobile Crisis Response team provides crisis intervention, de-escalation, and safety planning. Individuals can also access the 988 Suicide & Crisis Lifeline.

SUBSTANCE USE TREATMENT: SIU's Support Team for Addiction Recovery Treatment (START) clinic provides addiction treatment and medication-assisted recovery (MAR). Family Guidance Center offers inpatient and outpatient treatment, mobile MAR, and peer support. Alpharus provides residential and virtual support for individuals with substance use disorders.

RECOVERY AND HOUSING STABILITY: Supportive housing providers coordinate with treatment and healthcare partners to connect residents to counseling, medication management, substance use treatment, and ongoing recovery supports, promoting continuity of care and housing stability.

Heartland HOUSED, the CoC lead agency, promotes coordination through its Complex Care Case Conferencing Committee, which supports street outreach, shelter, and supportive housing staff serving individuals with complex needs.

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)

Expanding the workforce of peer recovery specialists and other peer support professionals has been an identified challenge across behavioral health and homelessness services in the Springfield area. To address this gap, SIU School of Medicine developed the Certified Recovery Support Specialist (CRSS) Pipeline Program in partnership with the Illinois Department of Human Services. The program trains individuals with lived experience of mental health or substance use recovery for professional peer support careers. Heartland HOUSED, the HCoC lead agency, participated on the SIU CRSS Pipeline Program Central Illinois Advisory Council, to help strengthen connections between the peer workforce and our homelessness response system. The pipeline is increasing the number of CRSS professionals working within HCoC agencies. One program graduate now serves as a Street Outreach Specialist with Heartland Housed, bringing lived experience into outreach services. CRSS staff use their lived experience to build trust, reduce barriers to treatment, navigate behavioral health and recovery services, and provide ongoing encouragement and support. Peer support has been particularly valuable for individuals hesitant to engage with traditional providers and has strengthened avenues to service connection within Street Outreach, Emergency Shelter, and Supportive Housing services. The HCoC Complex Care Committee expands access to peer support by providing housing providers with a forum to identify individuals who may benefit from CRSS engagement and connect them with appropriate peer resources. This allows peer support to be incorporated into individualized responses for people with complex behavioral health and substance use needs. HCoC also benefits from partner agencies with staff who bring lived experience to their work. SIU School of Medicine, Memorial Behavioral Health, and Family Guidance Center have staff with lived experience who provide additional avenues for peer connection, recovery navigation, and relationship-based support.

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

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

(limit 2,500 characters)

The Heartland Continuum of Care identifies individuals experiencing serious mental illness through Coordinated Entry, street outreach, emergency shelter, and collaboration with behavioral health providers. Trained Coordinated Entry skilled assessors engage individuals and families experiencing homelessness to identify barriers to housing stability, assess service needs, and document relevant information in HMIS. This process helps identify individuals who may benefit from intensive behavioral health services and supports appropriate referrals.

Street Outreach staff, Street Medicine, and emergency shelter staff work closely with Memorial Behavioral Health, PATH, and other mental health professionals to identify individuals with significant behavioral health needs. These partnerships help engage people who may be disconnected from traditional services and connect them to mental health treatment, substance use services, crisis response, case management, and other community supports.

The HCoC Complex Care Committee provides an additional mechanism for identifying and coordinating services for individuals experiencing homelessness with complex needs. The committee brings together street outreach staff, housing case managers, behavioral health professionals, and other community providers to discuss challenging cases, identify barriers, share resources, and develop coordinated approaches. Cases can be brought forward when an individual's needs exceed the capacity of a single provider, helping connect people to appropriate services while maintaining confidentiality.

Through Coordinated Entry, case conferencing, and collaboration with behavioral health and housing providers, HCoC works to ensure individuals experiencing serious mental illness receive the comprehensive services and ongoing support needed to achieve stability and maintain housing.

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)

Memorial Behavioral Health's Projects for Assistance in Transition from Homelessness (PATH) Program

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)

Heartland Continuum of Care (HCoC) coordinates with Memorial Behavioral Health's PATH team to engage individuals with severe mental illness (SMI) who are experiencing homelessness and connect them to behavioral health services, benefits, housing and ongoing support. MBH's PATH program works with Heartland Housed Street Outreach team, HCoC Street Outreach Task Group, and emergency shelter staff to identify individuals with SMI, establish relationships, facilitate behavioral health assessments, and connect individuals to treatment and housing resources.

MBH participates in the HCoC complex care committee each month and case conferencing as needed to provide street outreach, emergency shelter, transitional housing, and supportive housing staff with opportunities to share information about clients they are working with and get support on how to best assist them with connecting to mental health services.

MBH's PATH team spends time in the HCoC's largest Emergency Shelter, Helping Hands, and our day service provider, Washington Street Mission, each week to assist individuals utilizing shelter with navigating access to mental health services and assessing eligibility for services. The services provided by MBH enhances the level of care available in shelter for clients while also supporting and training shelter staff.

Each Friday, MBH, probation staff from Sangamon County problem solving courts for veterans, mental health, and drug court, Heartland Housed Street Outreach, and HCoC Service Providers meet to discuss clients engaged in both the court system and HCoC services. These regular meetings allow collaboration across systems while working to provide the best support to help people reach their goals and court obligations through the Problem Solving Specialty Court initiatives.

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 HCoC partners with Memorial Behavioral Health for Mobile Crisis Response utilizing 988 and other avenues of connection. Street Outreach, Shelter Providers, and other front line staff throughout the HCoC utilize 988, Springfield Police Department and MBH co-response, or direct lines to MBH staff whenever they encounter an individual in a mental health crisis.

1C-1f.	Treatment and Recovery Services—Availability of Units for Persons Reporting Chronic Substance Use.	
	You must upload the List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment attachment to the 4A. Attachments Screen.	

Identify the number of CoC Program-funded units that require program participant engagement in substance abuse treatment services as a condition of continued participation in the program in accordance with 24 CFR 578.75.	0
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1C-1g.	Treatment and Recovery Services—24/7 Access to Detox, Residential, or Inpatient Treatment.
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Is there 24/7 access to detox, residential, and inpatient behavioral health treatment within the geographic area of your CoC?	No
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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)

HCoC maintains multiple formal partnerships with Memorial Behavioral Health (MBH), a Community Mental Health Center and SAMHSA PATH provider. At the governance level, cross-system alignment is supported by the CoC Lead Agency Executive Director serving as Vice Chair of the MBH Board of Directors, ensuring unified service development across housing and behavioral health service. A formal MOU is in place for MBH PATH staff to participate in the HCoC HMIS System and information sharing.

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)

No CoC Program-funded projects operate sober housing.

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

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

(limit 2,500 characters)

HCoC partners with Memorial Behavioral Health, Envision Unlimited, and SIU to facilitate access to mental health treatment, case management, crisis response, and psychiatric care. Substance use treatment connections include SIU's START clinic, Family Guidance Center, and Alpharus, which provide addiction treatment, medication-assisted recovery, peer support, and residential and outpatient services. Housing providers coordinate with these partners to connect residents to ongoing treatment and recovery supports that promote housing stability.

Heartland HOUSED, the HCoC lead agency, utilizes case conferencing through its Complex Care Case Conferencing Committee to foster collaboration among multiple service providers working with individuals experiencing homelessness. The committee brings together outreach, shelter, supportive housing, and service providers to coordinate referrals, address complex needs, resolve barriers to care, and develop individualized strategies. These collaborative efforts strengthen transitions into permanent housing, support housing stability, and help prevent returns to homelessness.

HCoC's Emergency Shelter, Street Outreach, and Permanent Supportive Housing Community Standards emphasize warm hand-offs as a key practice for ensuring high-quality care, service continuity, and successful referrals. Warm handoffs have been especially important in improving how the HCoC Coordinated Entry System functions from the time of assessment and outreach to referral and entry into housing. The Complex Care Committee is another important tool to help staff across homeless response services, healthcare, mental health, and behavioral health work together to facilitate successful connections to services and housing.

1C-2.	Supportive Services Investment.
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	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$637,693
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.	\$380,936
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	60%
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.	\$0
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).	60%

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 Heartland Continuum of Care (HCoC) consults with the Illinois Department of Human Services (IDHS), ESG recipients, and community partners to align ESG funding decisions with state priorities and local homelessness response needs. HCoC receives an ESG allocation through the State of Illinois and works collaboratively with IDHS to understand funding priorities and incorporate them into local planning and allocation recommendations.

HCoC staff and ESG recipient agencies participate in monthly support calls hosted by IDHS to receive guidance from the ESG Grant Manager, stay informed about program expectations, and discuss implementation priorities. HCoC's Rating and Ranking Committee incorporates state priorities and locally identified needs into its review of ESG project applications and funding recommendations. Local priorities are informed by analysis of gaps in the homelessness response system, with particular emphasis on expanding Rapid Rehousing and Street Outreach. Funding recommendations also prioritize IDHS' goals of reducing the length of time individuals experience homelessness, preventing returns to homelessness, reducing first-time homelessness, and improving household income.

Heartland HOUSED, the HCoC lead agency, works closely with the Illinois Office to Prevent and End Homelessness to align local ESG planning with the state's Home Illinois Plan and broader strategic priorities. The lead agency also participates in the annual Home Illinois Summit to remain informed about state initiatives, emerging needs, and funding priorities.

HCoC will continue engaging IDHS, ESG recipients, and community partners to assess system needs, identify service gaps, communicate funding priorities, and inform future allocation decisions. This ongoing collaboration will help ensure ESG resources are directed toward strategies that strengthen the local homelessness response system and improve housing outcomes for individuals and families.

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 Heartland Continuum of Care (HCoC) coordinates closely with shelter providers to ensure individuals and families experiencing homelessness are connected to Coordinated Entry (CE), housing assistance, and other appropriate resources. Each HCoC shelter has trained CE assessors on staff who can engage eligible households and complete a housing assessment. The assessment documents homelessness history and other essential information used to determine eligibility and priority for available housing resources. Once a household is enrolled in CE, it is considered for available housing referrals based on eligibility, assessed needs, and community prioritization policies. Shelter staff and other housing providers regularly participate in case conferencing for households referred for housing. These discussions promote ongoing communication, identify barriers that could delay housing placement, and help ensure referrals are successfully connected to the appropriate housing provider and services.

HCoC shelter partners also participate in the Emergency and Transitional Shelter Task Group, which meets regularly to review shelter capacity and available resources, identify barriers to access, and coordinate strategies to address unmet needs. This collaboration allows providers to respond collectively to changes in shelter demand, improve referrals, and make the best use of available shelter and housing resources.

HCoC also maintains strong communication between street outreach and shelter providers. Street outreach teams can communicate directly with shelter staff and, when appropriate, help individuals experiencing unsheltered homelessness access available shelter. This connection is particularly important for individuals who may have difficulty navigating the homeless response system independently.

Through these coordinated processes, shelter providers serve as an important entry point to the broader HCoC system. By connecting households to Coordinated Entry, participating in case conferencing, sharing information about capacity and barriers, and maintaining direct communication with outreach and housing providers, HCoC shelters help ensure that individuals and families receive appropriate assistance and are connected to pathways toward permanent housing and stability.

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

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

(limit 2,500 characters)

Heartland Continuum of Care (HCoC) shares homelessness data with state and local government, community partners, and the public, as permitted by law, to inform system planning, identify service gaps, and improve housing outcomes. The Housing Inventory Count (HIC), Point-in-Time (PIT) Count, and System Performance Measures are publicly available on the Heartland HOUSED website and submitted annually to HUD through HDX 2.0. Built for Zero (BFZ) data is also publicly available through the website's dashboards, although it does not include Permanent Supportive Housing (PSH) or Rapid Rehousing (RRH) data. HCoC also shares information with the community during Continuum of Care meetings.

HCoC facilitates data reporting through HMIS and established grant reporting requirements. ESG-funded agencies submit data reports to IDHS quarterly and annually, which the state uses for its HUD reporting. HUD-funded agencies submit Annual Performance Reports (APRs) to HUD, while PATH program data is reported annually to SAMHSA. IDHS-funded programs also submit reports on the individuals they serve.

HCoC also uses coordinated outreach and Coordinated Entry meetings to support collaboration among service providers, including VA and HUD-VASH partners, subject to applicable confidentiality agreements and releases of information when protected data is involved. HCoC will continue exploring opportunities to use HMIS and Stella analytical tools to inform state and local planning and strengthen system performance.

All data sharing is conducted in accordance with applicable privacy laws and confidentiality requirements. Personally identifiable information and other protected client-level data are not shared with state or federal entities unless legally authorized.

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 Heartland Continuum of Care (HCoC) uses multiple data sources alongside HMIS to identify people experiencing or at risk of homelessness, improve care coordination, and connect individuals to appropriate housing and supportive services. These sources help identify people who may not yet be connected to HMIS and provide additional information for prioritizing outreach and intervention.

Community street outreach referrals are submitted through the HCoC Connect App, creating a coordinated mechanism for community members and providers to alert the homelessness response system when someone may be experiencing unsheltered homelessness. HCoC Street Outreach staff use these referrals, along with the Street Outreach By-Name List, to identify and engage individuals, coordinate services, and monitor progress toward housing.

HCoC also uses information from the Sangamon County Courts to identify individuals involved in the court system who do not have a current address or list a shelter as their address. This information creates an opportunity to identify housing instability earlier and connect individuals to prevention, outreach, Coordinated Entry, and housing resources before homelessness becomes prolonged or recurrent.

Memorial Behavioral Health's PATH program maintains a waitlist that provides another source for identifying individuals with serious mental illness who may need housing and supportive services. HCoC partners with PATH staff to strengthen connections between behavioral health services, outreach, shelter, and housing providers.

Through the FUSE program, local hospitals are also identifying people experiencing homelessness who frequently utilize emergency room services. This information helps partners identify individuals with complex needs who may benefit from intensive care coordination and supportive housing, allowing the system to address housing instability alongside recurring health care needs. These data sources complement HMIS by identifying people through multiple systems and creating opportunities for earlier intervention, coordinated care, and stronger connections to stable housing.

1C-6. Employment and Workforce Development Partnership.

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

(limit 2,500 characters)

The Heartland Continuum of Care partners with the Land of Lincoln Workforce Alliance and Capital Township's Workfare Program to connect individuals experiencing homelessness with employment and workforce development opportunities. These partnerships help individuals identify employment goals, access job training and placement services, and overcome barriers to 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)

Heartland Continuum of Care (HCoC) believes that positive, coordinated interactions with first responders and law enforcement can create opportunities to engage people experiencing homelessness in services and housing. HCoC street outreach projects work with first responders and community partners so that responses to crises can extend beyond the immediate emergency and connect individuals to ongoing support.

A key example is Springfield's Bridging Emergency and Community Outreach Network (BEACON), which brings together first responders, Memorial Behavioral Health professionals, and community resources to respond to mental health and substance-use-related crises. The Springfield Fire Department's BOLT mobile response vehicle provides an additional mechanism for responding in the community and connecting individuals to appropriate services. BEACON recognizes that people often need support beyond an emergency response and creates opportunities for follow-up connections to behavioral health care, substance use treatment, outreach, and other resources.

This approach complements HCoC's street outreach model. Outreach staff can build on connections made by first responders by engaging individuals after a crisis, addressing immediate barriers, and connecting them to Coordinated Entry, emergency shelter, prevention resources, and supportive housing. Collaboration also helps ensure appropriate follow-up when individuals are already connected to outreach or other service providers.

HCoC also participates in Springfield, Equip, Empower, and Deflect (SEED), a collaborative initiative bringing together Springfield Police Department, community leaders and service providers addressing homelessness, substance use, mental health, victim support, and family needs. The SEED initiative has created a referral process to help first responders make referrals to the collaborative so that service providers can work to connect the person referred to the most appropriate service..

By strengthening relationships among outreach teams, first responders, law enforcement, behavioral health providers, and community organizations, HCoC creates more opportunities for people experiencing homelessness to engage with services and ultimately connect to stable housing.

1C-8. Family or Support Network Reunification.

Describe how your CoC, or your recipients, assist with family or support-network reunification efforts for individuals experiencing homelessness or living in CoC Program-funded housing (e.g., case management, travel costs, arrangement of assistance in another geographic area).

(limit 2,500 characters)

Heartland Continuum of Care (HCoC) and its partner agencies support family and support-network reunification as an important strategy for helping individuals resolve homelessness and establish stable housing. When an individual has family or other supportive relationships in another community and reunification is safe and appropriate, outreach, shelter, and housing staff work with the individual to assess the opportunity, confirm a stable destination, and coordinate a successful transition.

Heartland HOUSED Street Outreach works closely with Washington Street Mission and the Springfield Police Department to connect individuals with transportation resources. Washington Street Mission's transportation program assists individuals who wish to return to family or another established support network. HCoC also utilizes the Heartland HOUSED Housing Problem Solving flexible fund to support relocation and reunification efforts. Flexible funding can help address transportation and other practical barriers that might otherwise prevent someone from reconnecting with family or another support network. Outreach staff help coordinate transportation, arrange tickets, confirm the individual's destination and plans, and provide transportation to Amtrak or Greyhound when needed.

State funded Shelter Diversion programs operated through Helping Hands and Contact Ministries also assist individuals with relocation and reunification when returning to family or another support network is a safe and appropriate alternative to entering shelter. These programs work with individuals to identify available supports and address barriers that may prevent them from successfully returning to a stable destination.

Youth Service Bureau (YSB) works to reunite homeless youth ages 18-24 back to their family or support network. When working with unaccompanied minors under age 18, YSB utilizes the Basic Center Grant in nearby areas. When working with out of state youth, YSB cooperates with the Interstate Juvenile Justice Commission's Interstate Compact

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)

Heartland Continuum of Care (HCoC) works collaboratively with local government, law enforcement, first responders, behavioral health providers, and community organizations to advance public safety while connecting people experiencing homelessness to appropriate services and housing. HCoC does not interfere with lawful local efforts to address encampments, public drug use, or situations involving danger to self or others.

HCoC has developed an Encampment Response Protocol to guide the community in closing encampments while helping individuals identify safe shelter and housing options. Street Outreach staff engage individuals during these transitions, connect them to Coordinated Entry, shelter, housing, and supportive services, and provide follow-up.

HCoC partners also connect individuals experiencing substance use challenges to residential treatment, sober living homes, medication-assisted recovery (MAR), and other treatment programs. These partnerships provide pathways to ongoing care.

For individuals experiencing behavioral health crises or presenting a danger to themselves or others, the HCoC Street Outreach team is trained to utilize the mobile crisis hotline and works closely with the State's Attorney's Office when an involuntary intervention is necessary. When an individual is taken to a hospital under an involuntary warrant, outreach staff maintain engagement, coordinate with hospital social workers on a safe discharge plan, and assist with obtaining medications and connecting the individual to follow-up appointments and services.

HCoC also partners with local law enforcement to help registered sex offenders access appropriate housing and supportive services. Through communication and coordination, partners identify available housing options, address barriers, and connect individuals with case management, mental health, substance use treatment, and other supports while maintaining compliance with applicable legal requirements. Illinois continues working toward substantial implementation of SORNA, and HCoC supports lawful information-sharing and coordination with law enforcement.

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)

Heartland Continuum of Care (HCoC) works collaboratively with the City of Springfield, law enforcement, and community service providers to coordinate encampment responses, address public safety concerns, and connect individuals experiencing unsheltered homelessness to appropriate services and housing.

A key local partnership is the Springfield Police Department's Homeless Outreach Team (HOT), which includes one officer and three social workers. The HOT Team collaborates with HCoC partners and Heartland HOUSED Street Outreach to identify encampments, engage individuals, connect them to available resources, and participate in the HCoC Encampment Response Protocol to coordinate encampment closures.

The City of Springfield Department of Public Works also plays an important role through its Zone Managers, who identify community needs throughout the city. Zone Managers work closely with Heartland HOUSED Street Outreach to share information about encampment locations and participate in the Encampment Response Protocol. These partnerships facilitate communication, improve coordination, and help ensure outreach and service providers can engage individuals before and during encampment closures.

The HCoC Encampment Response Protocol provides the community's established framework for coordinating encampment closures while helping individuals access safe shelter, Coordinated Entry, housing opportunities, and supportive services. Street Outreach staff work to build trust, assess individual needs, address barriers to housing, and provide follow-up to support transitions into stable housing.

Springfield does not have a camping ban ordinance. As a result, the Encampment Response Protocol is the primary mechanism available to coordinate encampment closures and connect individuals camping on public property to safe shelter and services. While this approach supports coordinated engagement, the absence of a specific ordinance can limit the City's ability to promptly close encampments when they emerge.

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)

Encampments consisting of five or more people congregating in one area are relatively uncommon throughout the Heartland Continuum of Care (HCoC) geographic area of Springfield and Sangamon County. Through coordinated outreach, community partnerships, and an established encampment response protocol, HCoC works to identify encampments, engage individuals experiencing unsheltered homelessness, and connect them to safe shelter and housing.

Heartland HOUSED Street Outreach staff, the Springfield Police Department's Homeless Outreach Team (HOT), the City's Fire Department and Department of Public Works, other law enforcement agencies throughout Sangamon County, and HCoC partner organizations help identify encampments and individuals who are unsheltered. Community members and faith-based outreach efforts also submit referrals through the HCoC Connect mobile app, providing an easy way to report locations where individuals may need outreach and support.

HCoC maintains an encampment by-name list and shared map to track individuals experiencing unsheltered homelessness and identify encampments and areas where people frequently stay. The Street Outreach Task Group, which includes Heartland HOUSED, HOT, Memorial Behavioral Health PATH, SIU Street Medicine, and other outreach partners, meets every two weeks to review individuals' needs, coordinate services, and determine next steps.

Outreach staff assist with obtaining identification, accessing Coordinated Entry, securing shelter, applying for SSI, SNAP, and TANF benefits, and connecting to medical care.

When encampments emerge, HCoC utilizes its Encampment Response Protocol to coordinate outreach and service providers in helping individuals access safe shelter and housing within the timeframe necessary to close the encampment. This collaborative process emphasizes individualized engagement and coordinated assistance.

HCoC's goal is to reduce unsheltered homelessness to zero. Beyond expanding outreach capacity, priorities include increasing transitional housing and non-congregate shelter options, developing partnerships with animal welfare organizations to provide temporary pet support, and advocating for Assertive Community Treatment and other services for individuals with severe mental illness.

Through these efforts, HCoC maintains a low number of encampments and has established action steps with a goal of resolving encampments within 30 days when they emerge.

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)

Heartland Continuum of Care (HCoC) works with local law enforcement, treatment providers, and community organizations to reduce public drug use and connect individuals experiencing substance use challenges to appropriate treatment and supportive services. Existing laws prohibit the public use of illicit drugs. Sangamon County's Problem-Solving Court provides an alternative pathway focused on addressing substance use and supporting recovery. A key local initiative is SEED (Springfield Empower Equip and Deflect), which HCoC partners with alongside Treatment Alternatives for Safe Communities (TASC) to establish referral pathways that allow law enforcement officers to connect individuals to treatment and other services. TASC staff respond to referrals from law enforcement and coordinate with Heartland Housed Street Outreach, Memorial Behavioral Health, and other HCoC and community partners to address substance use, mental health, and other co-occurring needs. SEED engages individuals in services and treatment rather than relying solely on enforcement responses.

Between July 1, 2025, and May 30, 2026, SEED partners received 233 referrals: 188 from law enforcement, 27 self-referrals, and 18 community referrals. Of those referred, 131 agreed to participate in services. Referral data identified 8 individuals with substance use disorder (SUD) needs only, 6 with mental health needs only, and 146 with SUD, mental health, and other co-occurring needs. In May 2026 alone, one individual entered an out-of-community detoxification program, three entered residential substance use treatment, and one entered outpatient treatment.

Some community partners identify the Illinois SAFE-T Act as a potential barrier because individuals may return to the community shortly after arrest, creating challenges for sustained engagement and continuity of care. HCoC will continue strengthening partnerships with law enforcement, TASC, SEED, and treatment providers to facilitate timely referrals, improve access to treatment, and support follow-up after release to continue building on the success of SEED.

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)

Between January 1 and September 30, 2026, illicit drug use and overdoses remain significant concerns in the Heartland Continuum of Care's geographic area of Springfield and Sangamon County. The Springfield Police Department Transparency Dashboard recorded 2,200 drug offense cases during this period, reflecting the ongoing presence of drug-related activity and the need for continued public safety and community-based responses.

To gain a better understanding of the reasons for justice involvement of people who are homeless in Sangamon County, Heartland HOUSED has worked with the Sangamon County State's Attorney and Public Defender to review data on types of arrest for people who are homeless and discuss ways to improve problem solving court processes and service connectivity to improve results. During May 2026, 12% of the charges for individuals listed as homeless were related to drug related offenses.

According to the Illinois Department of Public Health's Overdose Data Dashboard for 2025, Sangamon County recorded 139 non-fatal and 67 fatal overdose cases involving all listed substances. These figures highlight the serious health risks associated with substance use and the continued need for prevention, treatment, and recovery supports. Data is not readily available about overdoses that take place in public versus private spaces.

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)

Illinois law has established procedures for responding when an individual with mental illness presents a danger to themselves or others. Under the Illinois Mental Health and Developmental Disabilities Code, individuals who meet statutory criteria may be subject to emergency or court-ordered involuntary admission. Illinois also permits court-ordered outpatient treatment as a less restrictive alternative when appropriate.

Sangamon County's State's Attorney's Office assists families and treatment providers with petitions for individuals who may be a danger to themselves or others or unable to meet basic physical needs. Mental health hearings are held weekly.

Memorial Behavioral Health (MBH)'s Mobile Crisis Response efforts including 988 and co-response initiatives with the Springfield Police Department and Springfield Fire Department creates a clear line of professional support for HCoC partners with concerns about a person's welfare or any danger they pose to themselves or others. By calling 988, HCoC partners can quickly get connected to professional crisis responders who can quickly evaluate the next appropriate steps. From July 2024 to January 2026, MBH's Co-Response initiative with the Springfield Police Department alone served 704 participants. Heartland HOUSED Street Outreach team is trained to use the mobile crisis hotline (988) and works directly with the State's Attorney's Office when an involuntary application may be appropriate. When an individual is placed on an involuntary warrant and hospitalized, outreach staff visit the individual, coordinate with hospital social workers, and develop a safe discharge plan that includes medications, appointments, housing, and ongoing supports.

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

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

(limit 2,500 characters)

Heartland Continuum of Care (HCoC) works with local law enforcement to help individuals required to register as sex offenders access appropriate housing and supportive services while complying with legal requirements. Through collaboration and information-sharing, partners identify housing options, address eligibility barriers, and connect individuals to case management, mental health care, and substance use treatment. This coordinated approach supports housing stability while recognizing public safety and registration obligations. The federal Sex Offender Registration and Notification Act (SORNA), enacted in 2006, establishes baseline standards for sex offender registration and public notification. Illinois has adopted measures to strengthen compliance, including Public Act 97-578, registry technology improvements, and enhanced law enforcement information-sharing. Illinois has established a substantial framework for sex offender registration and information-sharing that addresses many core SORNA requirements. The U.S. Department of Justice's 2016 review recognized that Illinois met or did not substantially disserve the purposes of numerous requirements, including offenses subject to registration, required registration information, registration locations, initial registration procedures, and penalties for failure to register. Illinois also maintains processes for updating registry information and sharing it with law enforcement and federal databases.

HCoC partners with law enforcement and housing providers to verify applicable registration requirements, identify lawful housing options, and coordinate referrals while protecting confidential information. When restrictions limit information-sharing, partners will use authorized channels and seek clarification from appropriate authorities rather than disclose protected information. This collaboration helps ensure households are being served and are in compliance with legal 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)

The Heartland Continuum of Care (HCoC) uses a coordinated, multi-provider street outreach strategy to identify and engage individuals and families experiencing homelessness throughout its geographic area, including people who are not connected to traditional homeless services. The HCoC emphasizes consistent engagement and relationship-building, recognizing that individuals may require multiple contacts and approaches before they are ready to accept services.

Street outreach providers conduct regular in-person outreach in locations identified through the HCoC's regularly updated street outreach map. The map identifies known encampments, abandoned houses, and other locations where people may be experiencing unsheltered homelessness. Outreach is also initiated through referrals from community members, service providers, law enforcement, healthcare partners, and other community organizations.

The HCoC Connect street outreach app provides an additional community-based pathway for identifying people experiencing homelessness. Community members and outreach volunteers can use the app to report concerns about individuals or families experiencing homelessness, allowing local outreach providers to respond and establish connections to services.

The HCoC also maintains a street outreach By-Name List (BNL) that is regularly reviewed and updated to provide a current understanding of people experiencing unsheltered homelessness. The BNL helps coordinate outreach coverage, identify individuals or families who may not be fully engaged with services, track progress toward engagement, and facilitate connections to Coordinated Entry and housing opportunities.

To strengthen identification and documentation, HCoC uses a designated HMIS field to document when an individual is staying at an encampment. This information supports verification of homelessness and helps identify and track individuals whose locations may change frequently or who have limited connection to the service system.

Through these combined strategies, HCoC creates multiple pathways for identifying people experiencing homelessness and connecting them with outreach staff. Coordination among outreach providers, shelters, healthcare organizations, community partners, and other frontline agencies allows the HCoC to extend its reach across the community and provide repeated opportunities for engagement, service connection, and ultimately housing.

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

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

7.	Public Pre-K	Yes
8.	Tribal Home Visiting Program	No
	Other (limit 150 characters)	
9.	Mini O'Bierne Crisis Nursery for Children from Birth to Age 6	Yes

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

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

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

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

(limit 2,500 characters)

The Heartland Continuum of Care (HCoC) has written policies and procedures to ensure families and youth experiencing homelessness are informed of their educational rights under Title VII-B of the McKinney-Vento Homeless Assistance Act, as amended by the Every Student Succeeds Act. These requirements are incorporated into HCoC policy and the HCoC Community Standards for Rapid Rehousing and Permanent Supportive Housing, which include best practices for informing households of their eligibility for educational services.

Under HCoC policy, agencies serving children and youth experiencing homelessness provide parents, guardians, and unaccompanied youth with educational materials explaining their McKinney-Vento rights. At intake, each family with children experiencing homelessness and each unaccompanied youth receives a copy of the Education for Homeless Children and Youths Program Non-Regulatory Guidance.

Agency staff and caseworkers also inform families that children experiencing homelessness may remain in their school of origin regardless of where the family obtains shelter or temporary housing and that the school must provide transportation when required. This ensures families receive information about their educational rights when they first connect with homeless services.

The HCoC maintains contact information for school districts throughout Sangamon County through a resource guide developed and maintained by its local education agency partner, the Regional Office of Education #51 (ROE 51). Springfield Public Schools District #186 (SPS 186) employs Homeless Liaison staff who help families understand and access available educational resources. ROE 51 and SPS 186 are represented in HCoC Membership and both organizations also participate in the HCoC Youth Homelessness Task Group, helping identify gaps and challenges in connecting children and youth experiencing homelessness with educational services.

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)

Heartland Continuum of Care (HCoC) coordinates with the Illinois Department of Children and Family Services (DCFS), housing providers, and youth-serving organizations to help young people transition from foster care to stable, independent housing. Through partnerships, referrals, and dedicated housing programs, the CoC works to prevent homelessness among youth aging out of care and connect young adults to housing and supportive services.

DCFS provides housing and transitional support through programs including the Youth Housing Assistance Program (YHAP), which offers housing advocacy and financial assistance for eligible youth ages 18–21. Assistance may include security deposits, move-in expenses, rental subsidies, and emergency support for rent or utility arrears. Eligible youth may also access Fostering Youth to Independence (FYI) or Family Unification Program (FUP) housing vouchers, with continued support available under program guidelines. Youth participating in qualifying education or employment training programs may receive continued assistance beyond age 21.

HCoC and DCFS have established a Memorandum of Understanding with the Springfield Housing Authority to serve eligible youth through FUP, strengthening coordination between child welfare and housing systems.

Fifth Street Renaissance's Youth in Crisis program provides housing assistance and support for youth transitioning toward independence. The program currently serves 12 youth, with 3 holding a housing voucher or nearing voucher receipt.

Other participants receive subsidies or are working toward independent housing. The program typically serves an average of 13–14 youth.

Solid Rock Youth Transitional Services provides transitional housing and wraparound support for young people ages 17–26 who are in or aging out of foster care, at risk of homelessness, or transitioning to independent living. Solid Rock participates in the HCoC Youth Homelessness Task Group and receives referrals from CoC partners.

The Youth Service Bureau further strengthens the local response through its youth shelter, supportive services, and transitional housing programs, providing safe shelter and pathways toward stability and independent living for youth experiencing housing crises. Through these partnerships, the HCoC coordinates referrals, housing assistance, shelter, and supportive services to promote stable transitions from foster care and reduce the risk of homelessness.

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)

Sangamon County does not currently have any U.S. Department of Health and Human Services (HHS) Runaway and Homeless Youth (RHY)-funded Street Outreach Programs, Basic Center Programs, Transitional Living Programs, or Maternity Group Homes. The closest RHY-funded programs are in Bloomington and Jacksonville, IL.

HCoC youth service providers apply for RHY funding annually to try to grow program offerings available in our community. In the absence of local RHY-funded providers, Youth Service Bureau refers runaway youth to Basic Center Programs outside the area, which can provide temporary shelter for up to 21 days while efforts are made to reunite youth with their families.

HCoC also coordinates with the Illinois Department of Children and Family Services (DCFS), which administers the Comprehensive Community Based Youth Services Program and our local provider, Youth Service Bureau, to assist youth who have run away or been locked out of their homes. While family reunification is the primary goal, DCFS can provide alternative assistance when reunification is not possible. Through its Extended Family Support Program, DCFS may also support relative or fictive-kin caregivers, helping youth remain with trusted adults without entering formal DCFS care.

These partnerships provide pathways to immediate shelter, family reunification, and alternative support while the CoC continues working to address gaps in local youth homelessness services.

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)

Youth Service Bureau's Transitional Housing for Families Headed by Youth Ages 24 and Under serves families with children experiencing homelessness. The project is applying to transition from RRH to TH for this population through this competition.

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)

The Youth Service Bureau's Transitional Housing for Families Headed by Youth Ages 24 and Under project provides intensive, employment-focused supportive services designed to help youth increase income, pay rent, and achieve long-term self-sufficiency. Case managers assess each participant's education, employment, skills, and barriers and develop individualized goals connecting housing stability with economic independence.

Participants receive advocacy and support to enroll in high school, complete GED requirements, pursue post-secondary education or vocational training, and obtain employment. Program staff provide individualized job coaching, mentoring, work-readiness and soft-skills training, career and skills assessments, job-skills workbooks, and assistance securing employment or vocational training placements. Partnerships with local employers and workforce development programs create pathways to employment. Youth with disabilities are referred to vocational rehabilitation for individualized employment assistance.

With local United Way support, the program provides foundational workshops focused on education, employment, and housing, including career assessments, financial literacy, employability skills, interview preparation, and individualized employment planning. Services are tailored to each participant using skills assessments and employer feedback, with a focus on obtaining and retaining employment, increasing earnings, and developing the financial and life skills needed for independent housing.

The project will also leverage expanding local workforce opportunities. The Greater Springfield Chamber of Commerce has hired a Youth Workforce Director and is developing initiatives connecting youth with employers and career pathways. Career Connections connects high school students with local professionals to explore careers, while RPM Lab provides resume writing, interview preparation, workforce expectations, and mock interviews led by local HR professionals.

Together, these partnerships connect stable housing with education, career exploration, training, and employment, helping youth increase income, improve their ability to pay rent, and achieve long-term housing stability and independence.

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)

The Youth Service Bureau's Transitional Housing for Families Headed by Youth Ages 24 and Under project leverages mainstream family service systems to maximize HUD resources and provide youth who are parenting with comprehensive supports. The project connects eligible participants to Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and Medicaid, using these resources to address basic needs while youth work toward education, employment, and economic self-sufficiency.

TANF can provide eligible youth with cash assistance, work-readiness activities, subsidized employment, and child care assistance. These resources help remove barriers to employment and housing stability. SNAP helps meet food needs, allowing limited income to be directed toward rent and other household expenses, while Medicaid provides access to health care and reduces financial barriers that can interfere with employment and stability.

Through intensive case management, TH staff assess participants' needs and eligibility and connect them with appropriate mainstream benefits. Staff assist youth with applications, documentation, maintaining benefits, and coordinating services. For youth who are parenting, child care and family supports are particularly important to participation in education, job training, and employment.

This approach braids resources rather than duplicates services. HUD-funded transitional housing provides housing stability and intensive case management, while TANF, SNAP, Medicaid, and other mainstream resources address complementary economic, health, food, and family needs. Leveraging these systems maximizes HUD resources while helping youth stabilize their families, increase income, and develop the resources needed to sustain permanent housing and long-term independence.

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)

The Youth Service Bureau's Transitional Housing for Families Headed by Youth Ages 24 and Under project combines stable housing with childcare, parenting, healthcare, and education supports to help young parents experiencing homelessness achieve self-sufficiency while promoting the well-being of their children.

Housing stability provides a foundation for addressing the developmental and systemic barriers faced by young parents. TH staff provide intensive, trauma-informed case management and connect participants to reliable, safe childcare so parents can participate in employment, education, and job training. Parenting support helps young adults develop skills, strengthen family relationships, and address the effects of trauma while working to break cycles of homelessness and poverty.

The project also connects young families to healthcare. Staff help participants establish relationships with primary care providers and ensure parents and children have access to annual well-child visits and immunizations. For pregnant participants, staff facilitate prenatal and postpartum care, provide prenatal nutrition education, and assist with transportation to medical appointments.

Education is central to the project's self-sufficiency strategy. TH staff work with young parents to identify flexible educational pathways that accommodate parenting responsibilities, including high school completion, GED programs, post-secondary education, and vocational training. Staff assist with the FAFSA process, scholarship searches, and connections to educational opportunities.

By combining housing with childcare, parenting support, healthcare, and education, the project addresses the interconnected needs of young parents and their children. This integrated approach provides the stability and practical supports needed to pursue education and employment, strengthen parenting skills, improve health, and achieve long-term economic and housing stability.

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

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

(limit 500 characters)

The CoC partners with the Department of Veterans Affairs (VA), HUD VASH, Veterans Assistance Commission and Supportive Services for Veteran Families (SSVF) to connect veterans experiencing homelessness to housing. CoC and veteran partners meet biweekly to case conference all veteran households from the veteran by-name list to discuss housing assistance, supportive services and other community resources that can assist.

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:	

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

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

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

(limit 500 characters)

The HCoC partners with Sojourn Shelter & Services, Inc. to serve survivors of domestic violence, dating violence, sexual assault, and stalking. Sojourn Shelter provides shelter, advocacy, crisis intervention, counseling, and supportive services for survivors. Its Director of Shelter Services serves on the HCoC Board, and certified staff participating in task groups for Emergency Shelter and Coordinated Entry.

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)

HCoC partners with TASC's Bridge to Home (B2H), a permanent supportive housing program in Sangamon County that helps individuals returning from the Illinois Department of Corrections transition successfully to the community and avoid homelessness.

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)

HCoC has added a Frequent User System Engagement (FUSE) Pilot Program in partnership with Heartland Housed, Springfield Memorial Hospital, and HSHS St. John's Hospital. FUSE bridges health care and housing systems for individuals experiencing homelessness who frequently interact with emergency services and provides complex care coordination and support for stable housing to improve health and housing stability.

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)

HCoC partners with Helping Hands of Springfield through its Medical Respite program to serve aging and elderly individuals experiencing homelessness who have significant medical needs or are recovering from hospitalization. The program provides a safe recovery setting, care coordination, and connection to ongoing healthcare and housing services, helping older adults stabilize and transition toward appropriate long-term 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)

Helping Hands Park PSH is a renewal project in this application for individuals experiencing chronic homelessness.

1C-19a. Permanent Supportive Housing for Chronically Homeless Individuals and Families—On-site Behavioral Healthcare.

Describe how the project(s) identified in 1C-19 provides on-site behavioral healthcare.

(limit 2,500 characters)

The Helping Hands Park Avenue Permanent Supportive Housing project provides on-site behavioral healthcare through a partnership with Southern Illinois University (SIU). Helping Hands contracts with SIU to provide a Licensed Clinical Social Worker (LCSW) who delivers mental health services directly at the project, reducing barriers that can prevent residents from accessing behavioral healthcare in community settings.

The on-site LCSW provides residents with accessible, ongoing behavioral health support as part of the project's integrated supportive housing model. Services are coordinated with housing and case management staff to help residents address mental health needs that may affect housing stability, daily functioning, and progress toward greater independence.

The on-site model also allows staff to identify emerging behavioral health concerns and facilitate connections to additional community-based services when needs exceed the scope of on-site care. This may include referrals for more intensive mental health services, substance use treatment, crisis services, healthcare, or other specialized supports.

By bringing behavioral healthcare directly into the supportive housing environment, Helping Hands and SIU reduce transportation and access barriers and create more opportunities for residents to engage in services. The approach supports the project's broader goal of helping residents maintain housing stability while addressing the behavioral health needs that can contribute to housing instability.

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)

The Helping Hands Park Avenue Permanent Supportive Housing project follows the HCoC Permanent Supportive Housing Community Standards, which establish the community's policy for identifying and responding when a participant may need a higher level of care.

When project staff identify concerns that a participant's needs may exceed the supports available through the project, staff initiate a case conference to assess the participant's needs, current supports, risks, and available care options. The process emphasizes a coordinated, person-centered approach and seeks to identify the least restrictive setting that can safely and effectively meet the participant's needs while supporting housing stability.

The case conference draws on expertise and resources across the HCoC system, including the project's housing and case management staff, healthcare partners, and the community's medical respite team. Staff also coordinate with Senior Services of Central IL and the Division of Rehabilitation Services (DORS) to determine whether additional supports can be provided in the participant's current home, potentially allowing the individual to remain housed while receiving a greater level of assistance.

When a participant may require behavioral health or substance use treatment beyond what can be provided in the community, staff consult with appropriate treatment providers to evaluate available options. Providers help determine whether inpatient, residential, outpatient, or other community-based treatment is most appropriate based on the participant's needs.

1C-19c. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Assesses Readiness for Moving On.

Describe how the project(s) identified in 1C-19 has a policy for assessing program participant readiness for moving on to unsubsidized or other permanent housing.

(limit 2,500 characters)

In accordance with HCoC PSH Community Standards, all permanent supportive housing providers sign up all participants for independent subsidized housing (e.g., the Housing Choice Voucher program, Emergency Housing voucher, and other low-income housing waiting lists). If and when a time comes that the participant no longer needs the services provided, this will establish an option to move out of the project with continued rental assistance. Staff develop clear "moving on" plans with each client from the outset, if appropriate and desired by the client, setting goals and timelines for transitioning to more independent housing options when they are ready and able. Supportive Housing providers should provide ongoing support and navigation assistance for clients applying for and transitioning to other subsidized housing programs, ensuring a smooth and successful move. Park Ave utilizes the Moving On Assessment in HMIS to assess participant readiness to transition from permanent supportive housing to unsubsidized or other permanent housing. The assessment considers housing stability, income, support needs, and the participant's ability to maintain housing independently.

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

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

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

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

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

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

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

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

	Does your attachment include: 1. Project Names, 2. Project Scores, 3. Project Rank, 4. Project Status—Accepted, Rejected, Reduced Reallocated, Fully Reallocated, 5. Amount Requested from HUD, and 6. Reallocated Funds +/-.	Yes
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1D-2d.	Projects Rejected/Reduced—Notification Outside of e-snaps.	
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1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	08/06/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

1D-2e.	Projects Accepted—Notification Outside of e-snaps.	
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	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	08/06/2026
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1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
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	Describe:
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

(1) HCoC's Local Competition Policy includes the process for reallocation. The HCoC's policy gives the HCoC Rating and Ranking Committee the discretion to recommend projects for involuntary reallocation. The Rating and Ranking Committee determines if any renewal project should receive a decrease in funding (or an elimination of funding) due to substandard performance in outcomes and/or utilization of funds. Organizations are given all of the scoring data that the Rating and Ranking Committee uses along with their rationale for the decision to help them decide if they want to appeal the decision. Any funding captured from an existing project will be made available for reallocation to a new project that meets the requirements in the NOFO. The Rating and Ranking Committee makes their recommendation to the HCoC Board of Directors who votes on the decision as part of approving and created the Ranked Priority Listing of projects.

(2) Yes

(3) Yes

(4) HCoC reallocated less needed projects to maximize service opportunities and address gaps in the homeless response system.

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

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

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

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

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

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

(limit 2,500 characters)

(1) The addition of 3 full-time Street Outreach staff since our last PIT count has helped our continuum's Street Outreach Task Group improve its effectiveness in adding people to our Street Outreach By-Names-List and strengthen data quality. The additional staff has also allowed the community to assign caseloads across providers, supporting more consistent engagement and deeper connections with each unsheltered household while helping connect them to a broad range of services. This impacted the implementation of our PIT Count because we were able to pair volunteers with Street Outreach staff and partners with more expertise about where individuals may be located. This year's PIT Count benefitted from the growth in Street Outreach staff and Task Group efforts to engage a record number of volunteers from partner organizations to help with the effort. Additionally, we developed a mobile app that allowed community members and businesses to have an easy pathway to share locations where Street Outreach staff can connect with people who are unsheltered. This increase in capacity gave us more information and knowledge about individuals leading up to and during the PIT count.

(2) Our CoC has seen a continued expansion of non-congregant emergency shelter programs that have helped our growing outreach teams get people engaged with programs and leave unsheltered situations. The addition of 3 full-time Street Outreach staff since our last PIT count has helped us enroll more people into shelter programs while also getting a more accurate count on unsheltered homelessness. Expansion of local PSH programs helped the growth in the number of people in shelter be less than it would be otherwise.

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

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

(limit 2,500 characters)

During the evaluation period of November 15, 2024, through November 15, 2025, Heartland Continuum of Care (HCoC) implemented coordinated strategies to reduce the number of encampments and connect individuals experiencing unsheltered homelessness with housing and supportive services. During this period, the number of encampments with more than five people decreased from three to one. The HCoC successfully closed two larger encampments where individuals had accumulated personal belongings and other items.

Three key strategies contributed to these outcomes:

1. Temporary Housing Voucher Program: Heartland Housed piloted a temporary voucher program to provide an immediate alternative to living in encampments. This initiative created opportunities for individuals to move into temporary accommodations while outreach staff worked to identify longer-term housing options and connections to appropriate services.

2. Expanded Street Outreach Capacity: Heartland HOUSED expanded its Street Outreach team to three full-time staff members which increased capacity for more consistent outreach, relationship-building, service coordination, and assistance connecting individuals to shelter, temporary housing, and other resources. This sustained engagement helped address barriers to leaving encampments and connect with safe shelter.

3. Street Outreach Encampment Protocol: HCoC developed a written Street Outreach Encampment Protocol to guide a coordinated, consistent response to encampments. The protocol strengthened communication and collaboration among outreach providers, community partners, and other stakeholders. It established a structured approach to engaging individuals, identifying needs, coordinating available resources, and supporting transitions from encampments to appropriate alternatives.

These strategies led to the successful closure of two larger encampments and the reduction from three encampments with more than five people to one during the evaluation period. HCoC will continue to build on these efforts through collaborative outreach, coordinated services, and expanded pathways to housing stability.

2A-4a.	Reduce Encampments—Number of Encampments.	
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1. Enter the estimated number of encampments in the beginning of your evaluation period.	3
2. Enter the reduction in the number of encampments during your evaluation period.	1

2A-4b.	Reduce Encampments—Number of People in Encampments.	
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1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	29
2. Enter the reduction in the number of people in encampments during your evaluation period.	7

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 Heartland Continuum of Care (HCoC) will reduce first-time homelessness through a coordinated, data-driven prevention strategy that identifies households at risk, connects them to financial assistance, and strengthens community-wide diversion efforts. The Homelessness Prevention Task Group leads this work as part of the community's Crisis Response System.

The Task Group analyzes HMIS data on households entering homelessness, information from Sangamon County Community Resources, 211 call data, eviction court filings, and feedback from case managers and Community Action Agency staff to identify trends and risk factors. Priority risks include eviction, loss of income, and health-related crises. These findings guide prevention strategies, resource allocation, and training for organizations serving households at risk.

HCoC coordinates prevention resources through the Task Group, which trains community organizations, shares information about available assistance, and aligns referrals to prevent homelessness or divert households from emergency shelter into permanent housing. The CoC receives a Homelessness Prevention Grant that provides direct assistance to eligible households facing housing instability.

The Heartland Housing Help Line serves as a central access point for prevention and diversion services. Individuals and families referred by public, private, governmental, faith-based, and educational organizations receive an initial HMIS intake and are connected to agencies offering rental and utility assistance. Heartland HOUSED's Housing Problem Solving Specialist leads the Task Group and coordinates Helpline operations, prioritizing referrals based on available funding and adjusting pathways as resources change.

To address gaps when traditional assistance is unavailable, HCoC received a grant to develop and pilot a Housing Problem Solving Flexible Fund. This fund provides flexible financial support to households at imminent risk of homelessness when other resources are unavailable, helping resolve housing crises before households enter the homeless response system.

Through coordinated referrals, targeted financial assistance, ongoing data analysis, and community-wide collaboration, HCoC will strengthen early intervention, reduce entries into homelessness, and help individuals and families maintain stable housing.

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 Heartland Continuum of Care (HCoC) will reduce the length of time individuals and families remain homeless by expanding supportive housing, strengthening connections to mental health and substance use services, and helping households increase income and achieve long-term housing stability and self-sufficiency.

HCoC's data analysis identifies a significant need for additional supportive housing and services that help people improve their physical and mental health, increase income, and achieve greater independence. The community's strategic plan calls for creating 765 new housing opportunities by 2028. HCoC will expand rental assistance and case management while emphasizing individualized plans that help participants access employment and education, increase earned income, connect to mainstream benefits, and build financial stability.

HCoC recognizes that housing stability often depends on addressing behavioral health and other complex needs. Expanded housing-focused street outreach and collaborative care coordination will strengthen connections to mental health treatment, substance use services, and other community supports. Housing and service providers will work together to identify barriers, facilitate referrals, and help individuals access the care and ongoing support needed to achieve stability and sustain housing.

HCoC will continue expanding its Move On initiative, which helps households ready for greater independence transition to more independent housing, creating opportunities within the limited supply of supportive housing units. The Public Housing Authority's Moving to Work initiative has helped sustain and expand these efforts.

HCoC is also engaging landlords through a Landlord Risk Mitigation Fund and a Housing Navigator who educates property owners about supportive housing. Additionally, HCoC is developing a Flexible Housing Pool with local government, philanthropic, and healthcare partners to expand housing opportunities and supportive services.

Through these coordinated strategies, HCoC will shorten the time households experience homelessness while strengthening pathways to behavioral health stability, increased income, housing retention, and self-sufficiency and lead to a reduction in the length of time people experience homelessness in Sangamon County.

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

37.94%

Describe how you calculated the data for this response.

(limit 2,500 characters)

For this analysis, the CoC created a reporting group that included only Transitional Housing, Rapid Re-Housing, and Permanent Supportive Housing projects. The CoC then ran the FY2026 CoC APR report and reviewed Question 23c, Exit Destinations. Using the NOFO criteria, the CoC limited the analysis to the four eligible exit destinations identified: staying or living with family, permanent tenure; Staying or living with friends, permanent tenure; Rental by client, no ongoing housing subsidy; and owned by client, no ongoing housing subsidy. Of 243 total exits across 25 programs, 96 exits (37.94%) were to one of the four eligible exit destinations. The analysis included 8 Rapid Re-Housing programs, 9 Permanent Supportive Housing programs, and 8 Transitional Housing programs.

2A-8.	Housing Inventory Count (HIC) and Point-in-Time (PIT) Count Date.	
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	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/21/2026
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2A-8a.	HIC and PIT Count Data—HDX 2.0 Submission Date.	
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	Did your CoC submit its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count data in HDX 2.0 by April 30, 2026, 8:00 p.m. EDT?	Yes
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2A-8b.	Longitudinal System Analysis (LSA) Data—HDX 2.0 Submission Date.	
	You must upload your CoC's FY 2026 HDX Competition Report to the 4A. Attachments Screen.	

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

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	240	33	273	100.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	151	0	151	100.00%
4. Rapid Re-Housing (RRH) beds	97	0	65	67.01%
5. Permanent Supportive Housing (PSH) beds	322	0	291	90.37%
6. Other Permanent Housing (OPH) beds	0	0	0	0.00%

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

For each project type with a bed coverage rate that is 84.99 percent or lower in question 2A-9, describe:

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

(limit 2,500 characters)

(1) Over the next 12 months, the CoC will increase the RRH bed coverage by working with the one Supportive Services for Veteran Families program who is not entering data into our HMIS and is instead using the HMIS System where the organization's main offices are. HCoC will work with the agency specifically on ways to increase their bed coverage for the RRH programs by ensuring their beds are accurately entered and maintained in the HMIS of the CoC where the services are provided.

(2) HCoC will meet with the organization's leadership to discuss what challenges prevent the entering of services into the HCoC HMIS and work to support efforts to enter the data in the HCoC HMIS moving forward through supporting login access to HCoC HMIS, providing training, and being available to respond to any challenges the organization faces setting up their program. HCoC will also ensure that SSVF funding guidelines are being followed as they relate to proper HMIS entry of data. If SSVF funding allows for the current practice, HCoC will work with the organization on finding an appropriate and workable solution. HCoC will monitor progress and report back to the HCoC HMIS/CE Task Group and the HCoC Board of Directors.

3A. Policy Initiatives

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

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

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

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

3A-2	Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.
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Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes?

No

4A. Attachments Screen For All Application Questions

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

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

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

1.	You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.		
2.	You must upload an attachment for each document listed where 'Required?' is 'Yes'.		
3.	We prefer that you use PDF files, though other file types are supported—please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.		
4.	Attachments must match the questions they are associated with.		
5.	Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process.		
6.	If you cannot read the attachment, it is likely we cannot read it either.		
	. We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).		
	. We must be able to read everything you want us to consider in any attachment.		
7.	After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.		
8.	Only use the 'Other' attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.		
Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	Heartland 1C-1	09/30/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	Heartland 1C-1f	09/30/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	Heartland 1C-3	09/30/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	Heartland 1C-10	09/30/2026
05. 1D-1. Local Competition Scoring Tool	Yes	Heartland ID-1	09/30/2026

06. 1D-2c. Local Competition Selection Results	Yes	Heartland ID-2C	09/30/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	Heartland 2A-8b	09/30/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No	Heartland 3A1	09/30/2026
09. 3A-2a. Project List for Other Federal Statutes	No		
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No	Heartland 3A-DP	09/30/2026
11. Other	No		

Attachment Details

Document Description: Heartland 1C-1

Attachment Details

Document Description: Heartland 1C-1f

Attachment Details

Document Description: Heartland 1C-3

Attachment Details

Document Description: Heartland 1C-10

Attachment Details

Document Description: Heartland ID-1

Attachment Details

Document Description: Heartland ID-2C

Attachment Details

Document Description: Heartland 2A-8b

Attachment Details

Document Description: Heartland 3A1

Attachment Details

Document Description:

Attachment Details

Document Description: Heartland 3A-DP

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/27/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/30/2026
1C. Coordination and Engagement	09/30/2026
1D. Project Review/Ranking	09/30/2026
2A. HMIS Implementation	09/30/2026
3A. Policy Initiatives	09/30/2026
4A. Attachments Screen	09/30/2026
Submission Summary	No Input Required



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

List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment.....2

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

- (1) Helping Hands Park PSH**
- (2) FSR HUD Transitional Housing**



Heartland Continuum of Care 1C-1F
List of CoC Program Projects and the
Number of Units that Require Substance
Abuse Treatment

No projects in IL-513 have units that require substance abuse treatment.



Heartland Continuum of Care 1C-3
Language from Project
Supportive Service Agreements

Language from Project Supportive Service Agreements	2
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Language from Project Supportive Services Agreements

Projects within the HCoC have the option of creating their own Supportive Service Agreements or utilizing the HCoC Template. All six PSH/TH projects entered for FY26 HUD CoC funding have service Agreements.

MERCY Communities (1 PSH project, 1 TH Project) and Youth Service Bureau (2TH Projects) Utilize the HCoC Template

HCoC HUD Funded Program Supportive Services Participation Agreement

Supportive Services

As part of this housing program, you are expected to take part in supportive services. These services are designed to help you keep your housing, reach your goals, and live as independently as possible.

Supportive services may include:

- Meeting with a case manager
- Help finding or keeping a job
- Help getting benefits or other income
- Help with healthcare
- Mental health services
- Substance use services
- Help with daily living skills
- Help finding other community services

You will work with project staff to make a plan based on your needs and goals. Your plan may change as your needs change.

You are expected to meet with your case manager or other service providers and take part in the services that are part of your plan. Project staff will work with you to make it easier to take part in services and will help you connect with other providers when needed.

You will not be required to take part in a specific medical, mental health, or substance use treatment program if that service is not right for you. Staff will work with you to find services that meet your needs.

If you have trouble taking part in services, talk with your case manager or project staff. Staff will work with you to understand the problem, find solutions, and help you stay connected to services.

Your participation in supportive services is a condition of participating in this housing program. Any action taken because of a failure to participate in required services will follow HUD rules, HCoC policies, and the terms of your lease or occupancy agreement.

Participant Agreement

By signing this agreement, I understand that I am expected to take part in supportive services and work with project staff to maintain my housing and work toward my personal goals.

Participant Name: _____

Signature: _____

Date: _____



Permanent Supportive Housing Participant Guide and Agreement

Plain language guide to your rights and responsibilities

Revised September 2026

Effective date _____



YOUR GUIDE

Start Here

This guide explains the rules you must follow, the services Helping Hands offers, and the rights you keep while you receive Permanent Supportive Housing assistance. Read it with your lease or sublease. If this guide conflicts with federal, state, or local law, your HUD award, or your lease, the controlling requirement applies.

Permanent Supportive Housing is permanent housing. There is no fixed program deadline. You may remain assisted while you remain eligible for the project and follow lawful program and occupancy requirements.

Your Main Responsibilities

Rule	What you need to do
Use the unit as your home	Make the assisted unit your primary residence. Do not sublet it, assign it, or give possession to another person.
Pay your required share	Pay the rent or occupancy charge shown in your written calculation. Contact staff promptly if you cannot pay.
Report changes	Report income and household changes within 10 business days and provide information needed to recalculate your payment.
Allow required access	Allow legally noticed inspections, repairs, and housing administration visits. Ask to reschedule promptly if you have a barrier.
Protect the unit	Keep the unit clean, safe, and sanitary. Report repairs, leaks, pests, fire hazards, and safety problems promptly.
Follow the lease	Follow guest, occupancy, safety, nuisance, and other written lease or property rules.
Keep in contact	Keep your contact information current and communicate about long absences or housing problems.
Complete housing paperwork	Attend or reschedule required appointments for rent review, inspections, lease documents, and other housing administration.

Call 911 for an immediate emergency. Complete the contact list on page 11 and keep this guide with your lease.

HOUSING AND SERVICES

Your Rights

Helping Hands will administer the program fairly and will explain decisions that affect your housing assistance. You keep the rights provided by your lease, HUD rules, civil-rights laws, VAWA, and Illinois and local law.

Equal access. You will not be denied housing or services because of race, color, national origin, religion, sex, sexual orientation, gender identity, age, disability, familial status, marital status, or another status protected by law.

Religious choice. You will not be required to pray, attend worship, receive religious instruction, or hold a religious belief.

Reasonable accommodation. You may request a change to a rule, policy, communication method, or procedure when needed because of a disability. You may ask orally or in writing and do not need special legal words.

Voluntary services. Mental-health care, medical care, medication, substance-use treatment, and other disability-related services are voluntary. Helping Hands also treats case management and service-plan goals as voluntary under this program.

Privacy. Helping Hands will collect and share only information needed to operate the program, provide authorized services, meet reporting duties, or protect health and safety as permitted by law.

VAWA protection. Domestic violence, dating violence, sexual assault, or stalking will not be used against you when you otherwise qualify. You may ask about confidential documentation and an emergency transfer.

Safe housing. The assisted unit must pass the applicable HUD housing inspection before assistance starts and must be inspected at least annually.

Notice and review. Before program assistance is terminated, you have the right to written reasons, a review by an independent person, and prompt written notice of the final decision.

What Helping Hands Will Do

- Explain your rent or occupancy charge and give written notice when it changes.
- Offer housing-focused case management and connect you with services you choose.
- Use reasonable outreach when staff cannot reach you or believe you may be away.
- Consider disability, hospitalization, domestic violence, communication barriers, and other circumstances before adverse action.
- Use corrective action and less severe options when they can reasonably protect the housing and community.

Participant initials _____

PROGRAM ADMINISTRATION

Payments Income and Household Changes

Rent or Occupancy Charge

Your written calculation will state the amount you owe and the due date. The calculation depends on how your unit is funded and your current income. Helping Hands will not charge more than HUD rules allow.

Pay on time. If you cannot pay, contact staff as soon as possible. Staff will review the reason, any corrected income calculation, available hardship relief, and whether a reasonable repayment plan can prevent housing loss. Inability to pay is not treated the same as refusing to pay when able.

Hospitalization, incarceration, or another institutional stay does not automatically make your payment zero. Staff must use your actual current income, applicable deductions, and any approved hardship relief.

Income and Household Changes

Report the following changes to your case manager or housing staff within 10 business days unless an approved accommodation or documented emergency gives you more time:

- A job starting or ending, a change in wages or hours, or a new source of income
- A benefit starting, stopping, increasing, or decreasing
- A person moving in or out, a birth, a death, a marriage, or another household change
- A change in expenses or circumstances that may affect your calculation

Provide documents reasonably needed to verify income and household composition. You may ask staff for help obtaining documents or request an accommodation if a disability creates a barrier.

Contact Information

Keep your current phone number, email, mailing address, emergency contact, and authorized provider information on file when available. Tell staff promptly if your preferred or safe way to be contacted changes.

Financial Planning

Budgeting, savings plans, credit counseling, and financial coaching are offered and encouraged. They are not conditions for keeping your housing assistance. Separate assistance paid with non-CoC funds may have written eligibility limits that staff will explain before you choose whether to apply.

Participant initials _____

CONTINUED OCCUPANCY

Your Home Guests and Moves

Primary Residence

Use the assisted unit as your principal home. Do not rent it to someone else, assign the lease, allow another person to take it over, or use it mainly for another purpose. A temporary absence does not automatically mean you abandoned the unit.

Inspections Repairs and Entry

- Allow access after the notice required by your lease and law for inspections, repairs, maintenance, pest treatment, and required housing administration.
- Tell staff promptly when a disability, medical issue, employment schedule, safety concern, or other barrier requires rescheduling or another way to complete the visit.
- Report water leaks, loss of heat or utilities, pests, broken locks, fire hazards, and other serious conditions promptly.
- Do not block exits, disable safety devices, create serious sanitation or fire hazards, or intentionally or negligently damage the unit.

Guests and Household Members

Without prior written approval, a guest may stay no more than 14 consecutive nights and no more than 30 total nights in any rolling 12-month period. If your signed lease has a different written limit, the lease controls until it is lawfully changed. A guest who uses the unit address, receives mail, keeps most belongings, receives a key, or otherwise appears to establish residence must be reported and approved before continuing to stay.

You must ordinarily be present while a guest is in the unit. You may be held responsible under the lease for a guest's conduct, damage, nuisance, or illegal activity. Exceptions may be approved for a live-in aide, caregiver, VAWA safety need, reasonable accommodation, or another protected household arrangement.

Follow lease rules for pets. An assistance animal is not a pet and may be requested as a reasonable accommodation.

Moving

Get written approval before moving if you expect assistance to continue. Helping Hands ordinarily approves no more than one elective move in a 12-month period because of lease obligations and program cost. Exceptions may be approved for an emergency transfer under VAWA, reasonable accommodation, serious unit conditions, household-size changes, owner action, safety, or other good cause.

Assistance does not automatically follow you to any unit you choose. The rule depends on whether the project uses leasing or rental assistance, the grant area, unit approval, rent reasonableness, inspection, and available funding. Do not sign a new lease before housing staff approves the move.

Participant initials _____

PROPERTY AND COMMUNITY

Additional Lease and Safety Rules

These rules apply with your signed housing documents. Reasonable accommodation, VAWA protection, and other extenuating circumstances remain available.

Property Care and Maintenance

- Keep the unit, appliances, porches, and balconies reasonably clean, sanitary, and free of garbage or conditions that attract pests. Prevent damage caused by misuse or neglect. You may be responsible for repair costs when the lease and law allow the charge.
- Report water leaks, mold or moisture, pests, broken locks or windows, loss of heat or utilities, and plumbing or electrical problems immediately.
- Follow reasonable written preparation instructions for inspections, repairs, and pest treatment. Remove belongings from the work area when asked and allow access after lawful notice.

Fire Prevention and Exits

- Do not disable, cover, remove, or take batteries from smoke detectors, carbon monoxide detectors, sprinklers, or other safety equipment.
- Keep doors, windows, hallways, stairs, and fire exits clear. Do not accumulate belongings in a way that blocks escape, ventilation, heat, inspection, or repairs or creates a fire or infestation risk.
- Do not store prohibited gasoline, propane cylinders, fireworks, explosives, or other hazardous materials. Follow written rules for smoking, vaping, candles, grills, and space heaters. Unvented gas, oil, or kerosene heaters are prohibited.

Utilities Locks and Alterations

- Do not paint, change locks, install fixtures, alter plumbing or electrical systems, or make structural changes without prior written owner approval. A reasonable accommodation may be requested.
- Do not give keys, access cards, or entry codes to an unapproved person. Use appliances and utilities as intended, and do not tamper with meters, wiring, plumbing, heating, or safety devices.
- If your lease makes you responsible for utilities, keep required service active and contact staff before a shutoff so available assistance or a safety plan can be reviewed.

Community Standards

- Observe quiet hours from 10:00 PM to 8:00 AM and avoid unreasonable noise, disturbances, or nuisance at all other times.
- Keep common areas free of personal storage, garbage, and blocked access. Follow written parking, vehicle, smoking, and common-area rules.
- Do not engage in illegal drug manufacturing or distribution, violent criminal activity, threats, harassment, or other conduct on or near the property that threatens health, safety, or peaceful enjoyment.

Participant initials _____

WORKING TOGETHER

Services Case Management and Conduct

Services You May Choose

Helping Hands will offer housing-focused case management at least every two weeks and will offer an in-home meeting each month. You may accept, decline, or ask to change voluntary services. Missing a case-management visit or not completing a service-plan goal is not, by itself, a reason to terminate housing assistance.

Staff may offer help with benefits, employment, education, life skills, budgeting, food, transportation, health care, mental-health care, substance-use services, legal referrals, landlord communication, and housing stability. Availability depends on eligibility, funding, and community resources.

Staff may require administrative appointments needed to operate the housing program, including income review, inspection, lease signing, and required eligibility or payment documentation. If you cannot attend, contact staff promptly to reschedule or request an accommodation.

Safety and Conduct

You are responsible for conduct that affects the unit, the property, program operations, staff, neighbors, and other participants. Follow your lease and these objective safety rules:

- Do not make credible threats, commit violence, sexually harass another person, or use a weapon to threaten or harm someone.
- Do not intentionally cause major property damage or substantially interfere with another person's peaceful enjoyment of the property.
- Do not use the unit for criminal activity that threatens health, safety, or peaceful enjoyment or violates an enforceable lease term.
- Do not manufacture, distribute, or possess illegal substances in violation of law or your lease. Sobriety, treatment, and medication are not conditions of housing under this program. Conduct and lease violations remain enforceable.
- Do not post or share another participant's private medical, housing, or identifying information. Complaints and criticism are allowed, but threats, harassment, and unlawful disclosure are not.

If you arrive at an appointment unable to participate safely, staff may end or reschedule the meeting. Staff should address the behavior and immediate safety concern, not punish a disability or require treatment as a condition of housing.

Participant initials _____

IMPORTANT TIMING RULES

Extended Absences

Your unit must remain your primary residence. Tell Helping Hands before a planned absence expected to last more than 14 consecutive days when practicable. In an emergency, contact staff as soon as reasonably possible. Not giving advance notice may start an occupancy review, but it does not automatically prove abandonment.

Time away	What the rule means
More than 14 days	Notify staff before leaving when practicable. Share how staff can reach you and your expected return date.
More than 30 days	A personal absence ordinarily needs written approval. Approval may be given later if advance notice was not reasonably possible.
Up to 90 days	Helping Hands will review your intent to return, unit status, lease duties, household members, safety, funding, and any accommodation or VAWA need.
At or after 90 days	A personal absence ordinarily requires a written extension. Helping Hands may release the unit or begin a separate termination review, but day 90 or day 91 never causes automatic program termination.

Hospital Jail Treatment and Other Institutional Stays

Tell staff about the admission and expected discharge date when you can. Staff will ask about your plan to return and whether another household member remains in the unit.

For a unit funded with CoC rental assistance, HUD permits the payment during an institutional stay of no more than 90 days for each occurrence. After the stay exceeds 90 days, CoC rental-assistance funds cannot keep paying for that unit. You do not have to be exited from the program. Staff may use another eligible funding source, release the unit, or help you locate another unit after discharge.

For a unit funded with CoC leasing, HUD does not impose the same automatic 90-day payment cutoff. Helping Hands ordinarily holds the unit for up to 90 days and may approve a longer hold in writing. The unit may be released or reassigned while you remain enrolled and receive rehousing help, subject to funding and unit availability.

No contact alone is not abandonment. Helping Hands must use objective information and consider hospitalization, disability, incarceration, domestic violence, stalking, communication barriers, and other circumstances before deciding what action is appropriate.

If the qualifying household member dies or is incarcerated or institutionalized for more than 90 days, household members who were living in the unit have the continued-assistance rights required by HUD through the end of the lease then in effect.

CORRECTIVE ACTION**When a Rule May Have Been Broken**

A reported or verified violation does not automatically end your assistance. Except when immediate action is needed for a serious health or safety risk, Helping Hands will use a progressive response.

1. Explain the concern and identify the written rule or lease term involved.
2. Give you a chance to explain what happened and identify disability, communication, hospitalization, domestic violence, or another barrier.
3. Give written notice of the facts, what must be corrected, available help, and a reasonable correction date.
4. Offer a corrective-action, repayment, safety, or relocation plan when appropriate.
5. Require a supervisor to review the matter before a final warning or proposed program termination.

Issues That May Lead to Formal Review

May support formal review	Does not automatically support termination
Intentional fraud about eligibility, income, household members, or payment	A correctable mistake, missing document, or disability-related communication barrier
Repeated nonpayment when able to pay after notice and offered options	Poverty, inability to pay, or a pending benefit without a hardship review
Serious or repeated lease violations that continue after reasonable correction	A landlord complaint, notice, nonrenewal, eviction filing, or unit loss by itself
Credible serious threats, violence, intentional major damage, or immediate substantial risk	Conduct connected to disability or VAWA circumstances that has not been individually reviewed
Unauthorized subletting or objective evidence that the unit was abandoned	A temporary absence, institutional stay, or reaching day 90 or 91
Refusal to provide information legally required to calculate payment or administer assistance after notice	Declining voluntary case management, treatment, medication, recovery, employment, or service-plan goals

Helping Hands must consider the seriousness, actual harm, frequency, your responsibility, ability to correct the issue, reasonable accommodation, VAWA, previous interventions, and whether a less severe response can protect the program and community.

Participant initials _____

DUE PROCESS

Termination and Appeal Rights

Helping Hands may terminate assistance for a violation of written program requirements or conditions of occupancy. Because PSH serves people with significant housing barriers, assistance may be terminated only in the most severe cases after all extenuating circumstances are examined.

Before Assistance Can End

You will receive a written proposed-termination notice in an accessible format. The notice will state:

- The rule or occupancy condition involved and the facts, dates, and evidence supporting the proposal
- Corrective actions previously offered and your response, when applicable
- The proposed effective date
- How to request an oral or written review and the deadline
- Your right to present evidence, inspect relevant program records, and have a representative
- How to request reasonable accommodation, language help, and VAWA protection

How to Request Review

Ask orally or in writing within 10 business days after you receive or Helping Hands attempts to deliver the notice. A late request may be accepted for good cause, including hospitalization, disability, institutionalization, VAWA safety concerns, or failure to receive the notice.

The reviewer must be someone other than the person who made or approved the proposed termination and cannot be subordinate to that person. You may present oral or written objections, witnesses, documents, accommodation information, and VAWA information. You may bring an attorney, advocate, or other representative at your expense.

Assistance will not be finally terminated before the review and final written decision. Lawful emergency safety measures or a separate court process may still proceed. Helping Hands will issue a prompt written final decision, ordinarily within 10 business days after the review.

Unit Loss Eviction and Program Assistance

A landlord complaint, lease notice, eviction filing, loss of a unit, release of a master-leased unit, and termination of CoC assistance are separate actions. One does not automatically cause the others. Eviction requires the process provided by the lease and applicable law. If the unit is lost but program termination is not warranted, Helping Hands will make reasonable efforts to help relocate you, subject to funding and unit availability.

A program termination does not automatically bar you from receiving assistance from Helping Hands or another program at a later date.

Participant initials _____

PROTECTION AND HELP

Accommodation VAWA Privacy and Complaints

Reasonable Accommodation

You may request an accommodation orally or in writing at any time, including during corrective action or a termination review. You do not need to name a diagnosis or provide a complete medical record. When the disability or need is not obvious, Helping Hands may request only information reasonably needed to verify the disability-related need. Staff will consider effective alternatives and provide a written decision.

VAWA

If domestic violence, dating violence, sexual assault, or stalking affects your housing, tell any staff member you trust. Helping Hands will keep the information confidential as required by law, provide the HUD Notice of Occupancy Rights and certification form when required, and explain emergency transfer options. Criminal activity directly related to abuse will not be attributed to you solely because you were the survivor or threatened survivor.

Privacy and Information Sharing

Helping Hands may collect information needed for eligibility, income and rent calculations, inspections, leases, services you authorize, reporting, and lawful health or safety needs. A release of information should identify what may be shared, with whom, for what purpose, and when it expires. You may revoke a release to the extent permitted by law.

Grievances and Complaints

You may make a complaint or grievance orally or in writing. You do not have to use a special form, and staff will help if needed. Retaliation is prohibited. Program leadership will ordinarily provide a written response or status update within 10 business days. A grievance does not replace your separate right to appeal a proposed program termination.

Case Manager _____

Housing Staff _____

Office Phone _____

Maintenance or Landlord _____

Submit a grievance to _____

Request an accommodation from _____

Request a termination review from _____

Fair housing or legal help contact _____

Participant initials _____

SIGN AND KEEP A COPY

Participant Acknowledgment and Agreement

Initial each statement after staff reviews it with you. Ask questions about any statement you do not understand. Your signature confirms that you received and reviewed this guide and agree to follow the lawful written rules. It does not waive any right under your lease, HUD rules, VAWA, fair-housing law, disability law, or other applicable law.

Initials _____ 1. I will use the assisted unit as my primary residence and will not sublet it, assign it, or allow an unapproved person to establish residence.

Initials _____ 2. I will pay my required rent or occupancy charge and report income and household changes within 10 business days unless an approved exception applies.

Initials _____ 3. I will keep the unit clean and safe, report repairs, leaks, and pests promptly, allow legally noticed entry, and obtain written approval before changing locks or altering the unit.

Initials _____ 4. I will notify Helping Hands before a planned absence longer than 14 consecutive days when practicable and will request approval for a personal absence longer than 30 days.

Initials _____ 5. I understand that a 90-day absence or institutional stay may affect whether my unit can be held or paid for, but it does not automatically end my program assistance.

Initials _____ 6. I will follow the guest limit of 14 consecutive nights and 30 total nights in a rolling 12-month period unless my signed lease sets a different limit, and I understand that I may be held responsible under the lease for guest conduct and damage.

Initials _____ 7. I will keep safety devices working, keep exits clear, avoid prohibited fire hazards, and observe quiet hours from 10:00 PM to 8:00 AM.

Initials _____ 8. I will keep my contact information current and attend or reschedule required appointments for income review, inspections, lease documents, and other housing administration.

Initials _____ 9. I understand that case management and disability-related treatment services are voluntary and that declining them is not, by itself, grounds for termination.

Initials _____ 10. I understand the corrective-action process and my right to written notice, an independent review, and a final written decision before program assistance is terminated.

Initials _____ 11. I know I may request reasonable accommodation, VAWA protection, language help, or a grievance without retaliation.

Helping Hands may update this guide when rules or program requirements change. You will receive reasonable written notice of material changes. No update may reduce rights provided by controlling law.

Participant printed name

Date

Participant signature

Date

Staff printed name

Date

Staff signature

Date

FOR QUESTIONS AND REVIEW

Program Rule References

This guide summarizes the client-facing rules in Helping Hands of Springfield's Permanent Supportive Housing Policies and Procedures Manual. Staff must use the current HUD award, Continuum of Care written standards, lease, and applicable law when a question is not answered here.

Authority	Main subject
24 CFR 5.703	Housing condition standards, safety devices, exits, flammable materials, garbage, infestation, and other hazards
24 CFR 578.51	Rental assistance, moves, leases, and the 90-day institutional-stay rule for rental-assistance payments
24 CFR 578.75	Housing inspections, service agreements, and protections for remaining household members
24 CFR 578.77	Occupancy charges, resident rent, income review, and required verification
24 CFR 578.91	Written rules, termination notice, independent review, final written decision, and the most-severe-cases standard
24 CFR 578.93	Fair housing, equal opportunity, accessibility, and participant rights information
24 CFR part 5 subpart L	VAWA housing protections, confidentiality, documentation, and emergency transfers

Online Sources

- Electronic Code of Federal Regulations
<https://www.ecfr.gov/current/title-24/subtitle-B/chapter-V/subchapter-C/part-578>
- HUD Exchange CoC and ESG Additional Requirements <https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-additional-requirements/>
- HUD Institutional Stays and CoC and ESG Eligibility
<https://files.hudexchange.info/resources/documents/Institutional-Stays-and-CoC-and-ESG-Eligibility.pdf>

Keep This Guide

Keep your signed copy with your lease and other housing papers. Ask staff for another copy or an accessible format at any time. If a staff instruction appears to conflict with this guide, your lease, or a HUD requirement, ask for the instruction in writing and request supervisory review.

FIFTH STREET RENAISSANCE
FIFTH STREET RENAISSANCE

TRANSITIONAL HOUSING PROGRAM AND OCCUPANCY AGREEMENT

This Agreement is entered into on the ____ day of _____, 20____, between Fifth Street Renaissance (FSR) and:

Participant Name: _____

Assigned Housing/Unit: _____

Program Entry Date: _____

This Agreement establishes the requirements for participation in the Fifth Street Renaissance Transitional Housing Program and, when applicable, occupancy of FSR-controlled housing.

For Participants residing in scattered-site housing, this Agreement will be used together with a separate lease or sublease. The lease or sublease governs the terms of occupancy of the specific housing unit. This Agreement governs participation in the Transitional Housing Program. Participants are required to comply with both.

1. PURPOSE OF THE PROGRAM AND CONDITIONAL NATURE OF HOUSING

Fifth Street Renaissance Transitional Housing is a structured, temporary housing and supportive-services program designed to help individuals and families experiencing homelessness address the barriers that contributed to their homelessness and prepare for successful permanent housing.

FSR operates Transitional Housing using a low-barrier, individualized approach. Low-barrier programming means that FSR works to reduce unnecessary barriers to entering and remaining engaged in services. It does not mean that the Program is without expectations, responsibilities, or consequences.

Each Participant will receive individualized case management and programming based upon their needs, strengths, circumstances, barriers, abilities, and permanent-housing goals.

Housing provided through Fifth Street Renaissance Transitional Housing is a component of participation in the Transitional Housing Program and is not provided independently of the Program. Continued housing assistance is conditioned upon continued eligibility for the Program and compliance with applicable Program terms, conditions, responsibilities, and requirements.

Participants are expected to actively engage in case management, work toward identified goals, increase income when able, save toward permanent housing when income is available, participate in required services and activities, comply with housing requirements, and take reasonable steps toward obtaining and maintaining permanent housing.

Failure to comply with material Program requirements may result in corrective action up to and including termination from the Transitional Housing Program.

Termination from the Transitional Housing Program will end the Participant's eligibility for Program housing and will result in initiation of the process to terminate housing assistance or occupancy. Physical occupancy will end only after FSR follows the applicable lease, sublease, occupancy agreement, required notices, and all applicable legal procedures.

FSR will provide housing, case management, supportive services, referrals, advocacy, and other assistance appropriate to the Participant's individual needs.

2. LENGTH OF PARTICIPATION

Transitional Housing is temporary.

FSR anticipates that most Participants will complete the Program within approximately 12 to 18 months. Participants are expected to make consistent progress toward permanent housing throughout their stay.

Participation will be reviewed regularly.

FIFTH STREET RENAISSANCE

Continuation in the Program is based upon continued eligibility, compliance with Program requirements, active participation in the individualized service plan, available funding, and continued need for transitional housing.

Extensions beyond the normal Program period may be approved when permitted by applicable requirements and when FSR determines that additional time is necessary and appropriate based upon documented individual circumstances.

Participation in the Program does not guarantee housing for any specific length of time.

3. OCCUPANCY CHARGE

Participants with income may be required to pay an occupancy charge of up to 30% of income, as determined by FSR in accordance with the requirements of the applicable funding source, housing program, and housing arrangement. If an applicable funding source requires a different calculation or establishes a different maximum, that requirement will control.

If the Participant has no income, there is no occupancy charge.

FSR does not charge occupancy fees retroactively for periods during which the Participant had no income.

Once income begins, the occupancy charge will begin prospectively based upon the effective date established by FSR after the income is reported and verified.

Participants must:

- Accurately report all household income;
- Promptly report new income or changes in income;
- Provide requested income verification;
- Provide paycheck stubs or other documentation when requested; and
- Pay the required occupancy charge when due.

Failure to provide required income documentation or make required payments may result in a written Program violation and corrective action.

Repeated or continued noncompliance may result in termination proceedings.

4. REQUIRED INCOME REPORTING

Participants must report all sources of income or financial resources to FSR, whether received regularly, periodically, informally, or as a lump-sum payment.

Reportable income or resources include, but are not limited to:

- Employment wages;
- Self-employment income;
- Social Security or disability benefits;
- Unemployment compensation;
- Public benefits or cash assistance;
- Child support or maintenance received;
- Tips;
- Side jobs or informal work;
- Regular cash gifts or financial assistance from family or friends;

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- Lawsuit settlements or proceeds;
- Insurance settlements;
- Inheritances;
- Lottery or gambling proceeds;
- Taxable or nontaxable lump-sum payments;
- Cash payments received for services performed;
- Regular electronic transfers from another person; and
- Any other source of money or financial support received by the Participant.

Reporting a source of funds does not mean that every reported amount will be included in the occupancy-charge or savings calculation. FSR will determine whether and how reported income or financial resources are counted using the definitions and requirements applicable to the Participant's funding source and Program.

Participants must report income or financial resources even when they are unsure whether the funds count toward the occupancy-charge calculation.

Knowingly failing to report income or financial resources, concealing income, or providing materially false income information is a serious Program violation.

5. REQUIRED SAVINGS PROGRAM

Saving money for permanent housing is a required component of the Fifth Street Renaissance Transitional Housing Program for Participants who have income.

The standard savings requirement is 40% of the Participant's adjusted net income.

If the Participant has no income, there is no savings requirement.

FSR does not charge or require retroactive savings deposits for a period during which the Participant had no income.

Once income begins, the savings requirement begins prospectively after the income is reported and verified.

Savings are intended to prepare the Participant for the financial responsibilities associated with permanent housing, including security deposits, first month's rent, utility deposits, moving expenses, furniture and household supplies, transportation, emergency expenses, and other permanent-housing costs.

Participants must provide required income documentation so that the savings amount can be calculated accurately.

Savings payments are due according to the schedule established by FSR and will be documented with a receipt.

Individual Modification

FSR recognizes that individual circumstances may make the standard 40% savings requirement unreasonable or temporarily unmanageable.

A Participant may request a modification based upon documented circumstances such as necessary medical expenses, court-ordered obligations, childcare expenses, essential transportation costs, household or family obligations, temporary reduction in income, necessary debt resolution directly affecting housing stability, or other circumstances determined by FSR to warrant modification.

Any modification must be: 1) discussed with the Case Manager; 2) documented in the Participant's financial plan; 3) approved by the Program Administrator or Executive Director; and 4) reviewed periodically.

A Participant may not independently reduce, stop, or alter the required savings amount.

Until a modification is approved, the existing savings requirement remains in effect.

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Failure to make required savings payments without an approved modification may result in a written Program violation and corrective action.

Participant savings remain the property of the Participant and will be separately accounted for.

Required savings are a Program participation requirement and are separate from any rent or occupancy charge. Participant savings remain the Participant's property and will not be treated as Program revenue.

Funds will be returned to the Participant following Program exit in accordance with FSR's written Client Savings Account Policy and applicable requirements.

6. INDIVIDUALIZED SERVICE PLAN

Every Participant will work with their assigned Case Manager to establish an individualized service plan.

FSR recognizes that Participants enter Transitional Housing with different histories, abilities, needs, strengths, barriers, and circumstances. Program expectations will therefore be individualized when appropriate while maintaining the overall requirements and purpose of the Program.

The service plan may address permanent housing, employment, education or vocational training, income and benefits, budgeting and savings, physical health, mental health, substance-use treatment or recovery, transportation, legal obligations, family stability, life skills, identification and documentation, housing barriers, and other needs affecting housing stability.

Participants are required to actively work toward established goals.

Participants are not required to successfully accomplish every goal within a predetermined timeframe, but they are required to demonstrate ongoing effort, communication, participation, and cooperation.

A Participant who disagrees with a goal or believes a requirement has become unreasonable must discuss the issue with their Case Manager. The Participant may not simply discontinue participation.

7. WEEKLY PARTICIPATION REQUIREMENT

Participants are subject to the weekly participation requirement are expected to engage in a combination of approved employment, services, treatment, education, training, housing activities, or other self-sufficiency activities totaling at least 20 hours each week, unless an individualized modification has been approved.

Qualifying activities may include employment, job search, employment-readiness activities, vocational training, GED, high school, college, or other education, substance-use treatment, recovery activities, mental-health services, physical-health services related to stability, life-skills training, financial education, approved community service, probation or court requirements, Department of Children and Family Services activities, housing search, housing-readiness activities, benefits acquisition, case-management activities, and other activities approved by the Case Manager.

Participants must provide reasonable verification when requested.

A Participant may not substitute an unapproved activity for an activity contained in the service plan and assume that it satisfies the requirement.

Any exception or modification must be documented and approved.

8. CASE MANAGEMENT

Participants must maintain meaningful contact with their assigned Case Manager.

At minimum, Participants are required to have contact with their Case Manager at least weekly unless a different schedule has been approved.

Formal case-planning meetings will occur at least monthly and more frequently when needed.

Participants must attend scheduled appointments, arrive on time, participate meaningfully, bring requested documentation, notify the Case Manager in advance when unable to attend whenever reasonably possible, and promptly reschedule missed appointments.

Repeated missed appointments, failure to maintain contact, or refusal to participate may result in corrective action.

9. PERMANENT HOUSING RESPONSIBILITIES

Planning for permanent housing begins at Program entry.

Participants are expected to actively participate in identifying and securing appropriate permanent housing.

This may include completing housing applications, participating in housing searches, viewing available units, addressing rental or credit barriers, obtaining identification and necessary documents, increasing income when able, applying for benefits, saving for move-in expenses, resolving prior landlord issues when possible, and developing the skills necessary to maintain permanent housing.

A Participant may decline a housing option that is unsafe, inappropriate, unaffordable, or otherwise unsuitable.

Repeated refusal to participate in the housing process or repeated refusal of reasonable and appropriate housing opportunities without good cause may result in review of continued Program participation.

10. OCCUPANCY OF HOUSING

The assigned housing must be used as the Participant's primary residence and is provided as part of the Participant's enrollment in the Fifth Street Renaissance Transitional Housing Program.

The Participant understands that continued occupancy is dependent upon continued Program eligibility and compliance with applicable Program and housing requirements.

Participants may not allow unauthorized persons to enter or remain in bedrooms, Participant rooms, or other areas not designated for visitors; allow another person to establish residence in the housing; permit another person to sleep in or use their assigned room or unit; transfer possession of the unit or room to another person; sublet or assign the unit; provide keys or access devices to an unauthorized person; or abandon the unit without notifying FSR.

11. OVERNIGHT ABSENCES

Participants are expected to reside in their assigned housing each night unless an overnight absence has been approved.

Planned overnight absences must be approved in advance by the Participant's Case Manager.

The Participant must provide the requested information concerning the absence, including the expected date of departure and return.

Emergency circumstances in which advance approval could not reasonably be obtained must be reported to FSR as soon as reasonably possible.

Hospitalization, residential treatment, incarceration, work-related requirements, family emergencies, and other unusual circumstances will be addressed individually.

An unapproved, extended, or unexplained absence may result in a welfare check, Program violation, review of continued participation, or determination that the Participant has abandoned the housing when supported by the circumstances and applicable requirements.

Participants may not allow another person to use or occupy their room or housing while they are absent.

12. VISITORS

Visitors are permitted only in designated congregate or common areas and during approved visiting hours.

Visitors are not permitted in Participant bedrooms or assigned rooms.

This rule applies whether the room is single or double occupancy.

Participants may not allow a visitor to enter a bedroom or Participant room, sleep anywhere on the property, use the property as a residence, store substantial personal belongings at the property, use the address as their residence without authorization, remain in staff-only or other unauthorized areas, use another Participant's room, interfere with other Participants' privacy or use of the premises, or remain on the property outside permitted visiting hours.

Participants are responsible for the conduct of their visitors.

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FSR may prohibit a visitor whose behavior creates a safety concern, violates Program or property rules, substantially disrupts Program operations, or interferes with the rights of others.

13. KEYS AND ACCESS

Participants are responsible for all keys or access devices issued to them.

Keys may not be duplicated or given to another person without authorization.

Lost keys must be reported immediately.

Reasonable replacement costs may be charged when permitted.

All FSR-issued keys and access devices must be returned at exit.

14. CARE OF THE PROPERTY

Participants must maintain their room or unit in a reasonably clean, sanitary, and safe condition.

Participants are responsible for proper disposal of garbage, safe food storage, cleaning dishes and cooking areas, completing assigned household chores in shared housing, preventing avoidable damage, promptly reporting maintenance concerns, and following reasonable health and safety requirements.

Normal wear and tear is expected.

Participants are responsible for damage caused by intentional acts, negligence, misuse, or the actions of their guests when permitted by applicable requirements.

No alterations, additions, painting, installation, or other changes may be made without prior written approval.

15. ENTRY INTO ROOMS OR UNITS

FSR respects Participant privacy but retains the right to enter FSR-controlled housing when reasonably necessary and permitted.

Entry may occur during an emergency; when there is an immediate health or safety concern; for maintenance or repairs; for scheduled inspections; to investigate a reasonable concern regarding the condition of the property; to address a suspected abandonment; or as otherwise permitted under the applicable lease, sublease, occupancy agreement, or law.

Reasonable notice will be provided for routine inspections and maintenance whenever practicable.

16. PROGRAM CONDUCT

Participants must conduct themselves in a manner that protects the safety, dignity, privacy, and peaceful enjoyment of other Participants, staff, visitors, neighbors, property owners, contractors, and community members.

The following conduct is prohibited: violence; threats of violence; intimidation; harassment; bullying; theft; intentional property damage; possession of prohibited weapons; illegal activity that threatens health or safety; racial slurs; ethnic slurs; slurs or degrading language directed at another person based upon race, color, national origin, religion, sex, disability, age, sexual orientation, gender identity, or other protected or personal characteristic; repeated abusive, degrading, threatening, or highly disruptive language; allowing unauthorized persons into bedrooms, Participant rooms, staff areas, or other unauthorized areas; repeated serious disruption of Program operations; deliberately providing materially false information; and other serious violations identified in the Program Rules.

Disagreement, frustration, or conflict does not excuse threatening, discriminatory, degrading, or abusive conduct.

Serious violations may result in immediate protective action and initiation of termination proceedings.

17. EMPLOYMENT AND SELF-SUFFICIENCY

Participants who are able to work are expected to actively pursue employment or another approved income-development activity.

Loss of employment alone does not constitute grounds for termination.

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However, Participants may not repeatedly quit employment without good cause, refuse reasonable employment opportunities, or refuse to participate in agreed-upon employment, education, training, or job-search activities without addressing the issue with the Case Manager.

Repeated failure to participate may result in corrective action.

18. ALCOHOL, MARIJUANA, AND OTHER DRUGS

Fifth Street Renaissance Transitional Housing is an alcohol- and drug-free Program.

Use or possession of alcohol, illegal drugs, marijuana, cannabis products, or other non-prescribed intoxicating substances is prohibited while participating in the Transitional Housing Program and on FSR-controlled property.

This prohibition includes marijuana or cannabis that may otherwise be legal under state law.

Participants may not use prohibited substances on Program property; possess prohibited substances on Program property; bring prohibited substances onto Program property; permit visitors to bring or use prohibited substances on Program property; manufacture, distribute, or sell illegal drugs or other prohibited substances; or engage in substance-related conduct that threatens the health, safety, or peaceful enjoyment of others.

Prescription and over-the-counter medications used as directed are not prohibited.

FSR recognizes that substance-use disorders and relapse may be part of an individual's recovery process. When appropriate and consistent with safety and Program requirements, FSR may use increased case management, treatment referral, recovery planning, behavioral agreements, or other individualized interventions.

However, low-barrier and individualized programming does not eliminate the Participant's responsibility to comply with the Program's alcohol- and drug-free requirements.

Substance-related behavior that creates a serious health or safety risk may result in immediate protective action and initiation of termination proceedings.

19. CORRECTIVE ACTION

FSR expects Participants to comply with Program requirements.

When a violation occurs, FSR may use one or more of the following actions depending upon the seriousness, frequency, circumstances, risk involved, and the Participant's individualized needs:

1. Verbal counseling;
2. Written warning;
3. Corrective-action plan;
4. Increased case-management requirements;
5. Increased documentation requirements;
6. Behavioral agreement;
7. Referral to treatment or supportive services;
8. Final written warning; or
9. Termination proceedings.

FSR is not required to use each step or use the steps in this order.

The use of individualized interventions does not mean that a Program rule has been waived.

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Serious violations involving violence, credible threats, weapons, significant property damage, illegal activity affecting health or safety, or other immediate risks may result in immediate protective measures and initiation of termination proceedings.

20. TERMINATION FROM THE PROGRAM

Program assistance may be terminated when a Participant materially violates Program requirements, fails to comply with an approved corrective-action plan, abandons participation, is no longer eligible, or engages in conduct warranting termination.

Termination from the Transitional Housing Program will end the Participant's eligibility for Program housing and will result in initiation of the process to terminate housing assistance or occupancy. Physical occupancy will end only after FSR follows the applicable lease, sublease, occupancy agreement, required notices, and applicable legal procedures.

For Participants residing in scattered-site housing, termination from the Transitional Housing Program will end eligibility to remain in the Program-funded unit and will result in initiation of termination under the Participant's sublease. The Participant's physical right to occupy the unit will end only through the notice and legal process required by the sublease and applicable law.

Termination of actual occupancy will be implemented through the applicable lease, sublease, occupancy agreement, notice process, and applicable legal requirements.

Termination is not automatic solely because a violation has occurred.

Before final termination, the Participant will receive: 1) written notice identifying the reason for the proposed termination; 2) an opportunity to provide information or objections; 3) review of the proposed termination by an appropriate person who was not responsible for making or approving the initial decision; and 4) written notice of the final determination.

A Participant's refusal to sign a warning, corrective-action plan, termination notice, or other document does not invalidate the document. Staff will document the refusal.

Immediate protective action may be taken when necessary to address a serious health or safety concern.

21. GRIEVANCE PROCESS

Participants are encouraged to attempt to resolve routine concerns with their Case Manager.

If unresolved, the Participant may bring the concern to the Program Administrator.

If the issue remains unresolved, the Participant may request review by the Executive Director or other designated reviewer.

Termination appeals will follow the termination process described in this Agreement.

Use of the grievance process will not result in retaliation.

22. INDIVIDUALIZED PROGRAMMING AND MODIFICATIONS

FSR's Transitional Housing Program is individualized.

Participants may have different service plans, schedules, goals, requirements, accommodations, or approved modifications based upon individual circumstances.

A Participant may not assume that a rule does not apply because another Participant has different requirements; FSR approved an exception for another Participant; a requirement was modified on a prior occasion; staff did not immediately address a previous violation; or a violation by another Participant has not resulted in the same response.

Participants who need a modification to a Program requirement must communicate that need to their Case Manager and obtain approval.

A Participant may not create their own exception to a Program requirement.

An individualized modification applies only to the Participant and circumstances for which it was approved and does not permanently change the general Program rule.

23. SAFETY AND PROTECTED CIRCUMSTANCES

FSR will consider applicable protections related to disability, domestic violence, dating violence, sexual assault, stalking, and other protected circumstances.

Participants should notify FSR when a Program requirement, housing situation, or safety concern requires individualized consideration.

Nothing in this Agreement requires a Participant to remain in an unsafe situation.

24. CONFIDENTIALITY

Participant information will be maintained and shared in accordance with FSR policy, applicable confidentiality requirements, and law.

Participants are also expected to respect the privacy of other Participants.

Information learned about another Participant through shared living arrangements, meetings, or Program activities should not be shared outside the Program.

25. PERSONAL PROPERTY FOLLOWING DEPARTURE

Participants are responsible for removing their personal belongings when they leave the Program or housing.

Participants are responsible for removing their personal belongings when they leave the Program or housing. FSR will ordinarily hold personal property left behind for up to 14 calendar days to allow the Participant to make retrieval arrangements, unless a longer period is required by applicable law or approved because the Participant is hospitalized, incarcerated, or has another documented circumstance preventing timely retrieval. Property that remains after the applicable holding period will be handled in accordance with FSR's written property procedures and applicable law; this Agreement does not waive any notice or property-disposition requirement imposed by law.

When a Participant is hospitalized or incarcerated, FSR will work with the Participant when reasonably possible to establish a plan and timeframe for removal or storage of belongings.

FSR is not required to store property indefinitely.

If the Participant wishes to authorize another person to retrieve personal belongings, arrangements must be made in advance with the Participant's Case Manager.

FSR may require written authorization from the Participant; identification from the person retrieving the property; an agreed date and time for pickup; and documentation of the property released.

FSR will not release a Participant's belongings to another person solely because that individual states that the Participant gave permission.

Property remaining beyond the applicable period may be disposed of in accordance with FSR procedures and applicable law.

26. PROGRAM RULES

The Fifth Street Renaissance Transitional Housing Program Rules are incorporated into this Agreement.

Participants are required to read and follow those rules.

A Participant's statement that they did not read, remember, or understand a rule will not excuse a violation when the rule was provided and reasonably explained to the Participant.

Participants are expected to ask questions about requirements they do not understand.

27. SEPARATE LEASE OR SUBLEASE

Participants residing in scattered-site or other leased housing will sign a separate lease or sublease when required.

The Participant acknowledges that scattered-site housing is made available because of the Participant's enrollment in the Fifth Street Renaissance Transitional Housing Program. The housing is Program-based housing and is not offered independently of participation in the Transitional Housing Program.

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The Participant must comply with both the lease or sublease and this Program Agreement.

The lease or sublease governs the physical occupancy of the specific unit.

This Agreement governs participation in the Transitional Housing Program.

Violation of one document may also constitute a violation of the other when the conduct affects both housing and Program participation.

For scattered-site housing, termination from the Transitional Housing Program will end eligibility to remain in the Program-funded unit and will result in initiation of termination under the Participant's sublease. Physical occupancy will end only after required notices and applicable legal procedures are completed.

Any scattered-site sublease package will include disclosures, notices, and addenda required by Illinois law and by the applicable funding source.

The termination of physical occupancy will be implemented through the applicable sublease, required notice process, and applicable law.

Nothing in this Agreement eliminates rights or responsibilities created by an applicable lease, sublease, occupancy agreement, or law.

28. NO WAIVER THROUGH NON-ENFORCEMENT

Failure by FSR to immediately enforce a Program rule, address a violation, or impose a consequence on one occasion does not waive FSR's right to enforce the same rule in the future.

An exception, accommodation, or modification made for one Participant does not create an exception for another Participant.

A Participant may not rely upon the treatment of another Participant as authority to disregard their own Program requirements.

29. SEVERABILITY

If any provision of this Agreement is determined to be invalid or unenforceable, the remaining provisions will continue to apply to the extent permitted.

30. ENTIRE PROGRAM AGREEMENT

This Agreement, the Transitional Housing Program Rules, the Individualized Participation and Savings Plan, applicable written addenda, and any separate lease or sublease establish the requirements governing the Participant's housing and Program participation.

Participants are responsible for complying with all documents applicable to their placement.

PARTICIPANT ACKNOWLEDGMENT

- _____ I understand that the housing provided to me is part of the Fifth Street Renaissance Transitional Housing Program.
- _____ I understand that the housing is not provided independently of participation in the Program.
- _____ I understand that continued housing assistance is conditioned upon continued eligibility and compliance with applicable Program and housing requirements.
- _____ I understand that termination from the Transitional Housing Program ends my eligibility for Program housing and will result in initiation of the process to terminate my housing assistance or occupancy, subject to required notices and applicable legal procedures.
- _____ If I reside in scattered-site housing, I understand that termination from the Program will result in termination of my right to occupy that unit.
- _____ I have received and reviewed this Agreement.

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- _____ I have listened as the entire packet (Agreement, Rules, Plan) was read aloud to me by the Case Manager.
- _____ I have received the Transitional Housing Program Rules.
- _____ I understand that the Program uses a low-barrier, individualized approach but still has required terms, conditions, responsibilities, and expectations.
- _____ I understand that individualized programming does not give me permission to disregard a requirement unless a modification has been approved.
- _____ I understand the 30% occupancy-charge requirement when I have income.
- _____ I understand that there is no occupancy charge when I have no income and that FSR does not charge the occupancy amount retroactively.
- _____ I understand the 40% savings requirement when I have income and the process for requesting an individualized modification.
- _____ I understand that there is no savings requirement while I have no income and that savings are not assessed retroactively.
- _____ I understand that I am required to report all income and financial resources.
- _____ I understand the weekly participation requirements.
- _____ I understand that planned overnight absences must be approved by my Case Manager.
- _____ I understand the visitor restrictions, including that visitors are not permitted in Participant bedrooms or assigned rooms.
- _____ I understand the Program's prohibition on alcohol, marijuana, and other drugs.
- _____ I understand that I must maintain regular contact with my Case Manager.
- _____ I understand that violations may result in corrective action or termination.
- _____ I understand the termination and grievance process.
- _____ I understand that a separate lease or sublease may also apply to my housing.
- _____ I have had an opportunity to ask questions.

Participant: _____

Signature: _____

Date: _____

FSR Case Manager: _____

Signature: _____

Date: _____

Program Administrator: _____

Date: _____

FIFTH STREET RENAISSANCE

FIFTH STREET RENAISSANCE
FIFTH STREET RENAISSANCE
TRANSITIONAL HOUSING PROGRAM RULES

DOCUMENT 2 OF 3

These rules apply to all Participants in Fifth Street Renaissance Transitional Housing unless a written program-specific requirement or approved individualized modification states otherwise. **The Program uses a low-barrier, individualized approach, but low barrier does not mean no rules or expectations.**

Failure to comply with Program requirements may result in corrective action up to and including termination from the Program and termination of housing assistance or occupancy, subject to the applicable notice and legal process.

1. RESPECT, CONDUCT, AND SAFETY

- Participants must treat staff, other Participants, visitors, neighbors, property owners, contractors, and community members with reasonable courtesy and respect.
- Violence, threats, intimidation, harassment, bullying, theft, and intentional property damage are prohibited.
- Racial, ethnic, religious, sexual, disability-related, or other slurs or degrading language directed at another person are prohibited.
- Weapons and other dangerous items prohibited by FSR policy or applicable law are not permitted.
- Participants must follow reasonable health, safety, fire, emergency, and property rules.
- Participants are responsible for the conduct of their guests.

2. HOUSING AND HOUSEKEEPING

- Participants must maintain their room or unit in a reasonably clean, sanitary, and safe condition.
- Garbage must be properly disposed of, food must be safely stored, and dishes and cooking areas must be cleaned after use.
- Participants living in shared or congregate housing must complete assigned household chores.
- Maintenance concerns, leaks, plumbing or electrical problems, pest concerns, damaged equipment, and other property concerns must be reported promptly.
- FSR-owned furniture, equipment, household items, keys, and supplies may not be removed without authorization.
- Participants may not paint, alter locks, install fixtures, or otherwise modify the property without prior written approval.

3. SMOKING

- Smoking is prohibited inside FSR-controlled housing.
- Smoking is permitted only in designated exterior areas when such an area is provided.
- Smoking materials must be fully extinguished and properly disposed of.

4. VISITORS AND UNAUTHORIZED AREAS

- Visitors are permitted only in designated congregate or common areas and only during approved visiting hours.
- Visitors are not permitted in Participant bedrooms or assigned rooms, including rooms occupied by only one Participant.
- Visitors may not enter staff-only areas, another Participant's room, or any other unauthorized area.
- Overnight guests are prohibited.

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- Participants may not allow any visitor or other unauthorized person to establish residence in the housing, sleep on the property, store substantial belongings there, or otherwise function as an unauthorized household member.
- Participants are responsible for the conduct of their visitors. FSR may restrict or prohibit a visitor whose conduct violates Program or property rules, creates a safety concern, substantially disrupts Program operations, or interferes with the rights of others.

5. KEYS AND SECURITY

- Participants may not give keys, access codes, or access devices to another person or make unauthorized copies.
- Lost or stolen keys must be reported immediately.
- Exterior doors must remain secured in accordance with property requirements.

6. CASE MANAGEMENT AND INDIVIDUALIZED PROGRAMMING

- Participants must maintain meaningful contact with their assigned Case Manager at least weekly unless another schedule has been approved.
- Participants must attend scheduled case-management appointments, participate meaningfully, and provide requested documentation.
- FSR uses individualized programming. Participants may have different goals, activities, schedules, accommodations, or approved modifications based upon their circumstances.
- A Participant may not assume that a requirement does not apply because another Participant has different requirements or because an exception was approved for another person.
- If a Participant needs a modification, the Participant must discuss the need with the Case Manager and obtain approval rather than independently disregarding the requirement.

7. WEEKLY PARTICIPATION

- Unless an individualized modification has been approved, Participants must engage in at least 20 hours per week of approved employment, services, education, training, treatment, housing activities, recovery activities, or other approved self-sufficiency activities.
- Participants must provide reasonable verification of required activities when requested.
- Participants may not independently substitute unapproved activities for activities identified in their plan.

8. EMPLOYMENT, INCOME, AND REPORTING

- Participants who are able to work must actively pursue employment or another approved income-development activity.
- Loss of employment alone will not automatically result in termination, but the Participant must promptly report the loss and work with the Case Manager to revise the plan.
- Participants must accurately and promptly report all income and financial resources, including wages, benefits, side work, tips, regular cash gifts or financial support from family or friends, lawsuit or insurance proceeds, inheritances, lump-sum payments, and other money received.
- Participants must report money received even if they are unsure whether it will be counted in the occupancy-charge or savings calculation. FSR will determine how reported funds are treated under the applicable Program requirements.
- Knowingly concealing income or providing materially false income information is a serious Program violation.

9. OCCUPANCY CHARGE AND SAVINGS

- Participants with income may be required to pay an occupancy charge of up to 30% of income, as determined by FSR in accordance with the requirements applicable to the Participant's funding source

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and housing arrangement. If an applicable funding source requires a different calculation or maximum, that requirement controls.

- If a Participant has no income, there is no occupancy charge. FSR does not assess occupancy charges retroactively for periods during which the Participant had no income.
- Participants with income are expected to save 40% of adjusted net income toward permanent housing unless an individualized modification has been approved.
- If a Participant has no income, there is no savings requirement. FSR does not require retroactive savings deposits for periods during which the Participant had no income.
- Participants may not independently reduce, stop, or alter the required occupancy or savings amount. Any approved modification must be documented.

10. PERMANENT HOUSING

- Planning for permanent housing begins at Program entry.
- Participants must actively participate in housing search, applications, document collection, income development, savings, and other reasonable activities identified in their housing plan.
- Participants may decline housing that is unsafe, inappropriate, unaffordable, or otherwise unsuitable.
- Repeated refusal to participate in the housing process or repeated refusal of reasonable and appropriate housing opportunities without good cause may result in review of continued Program participation.

11. OVERNIGHT ABSENCES

- The assigned housing must be the Participant's primary residence.
- Planned overnight absences must be approved in advance by the Participant's Case Manager.
- An emergency absence that could not reasonably be approved in advance must be reported to FSR as soon as reasonably possible.
- Participants may not allow another person to use or occupy their room or housing while they are absent.
- Extended, unapproved, or unexplained absences may result in a welfare check, Program violation, review of continued participation, or an abandonment determination when supported by the circumstances and applicable requirements.

12. ALCOHOL, MARIJUANA, AND OTHER DRUGS

- Fifth Street Renaissance Transitional Housing is an alcohol- and drug-free Program.
- Use or possession of alcohol, illegal drugs, marijuana or cannabis products, or other non-prescribed intoxicating substances is prohibited while participating in the Transitional Housing Program and on FSR-controlled property. This includes marijuana or cannabis that may otherwise be legal under state law.
- Participants may not permit visitors to bring or use prohibited substances on the property.
- Prescription and over-the-counter medications used as directed are not prohibited.
- When appropriate, FSR may use treatment referral, recovery planning, increased case management, behavioral agreements, or other individualized interventions. Individualized programming does not eliminate the Participant's responsibility to comply with the alcohol- and drug-free requirement.

13. CORRECTIVE ACTION

- Violations will be documented.
- Depending upon the seriousness, frequency, circumstances, risk, and individualized needs involved, FSR may use verbal counseling, written warnings, corrective-action plans, increased case management, behavioral agreements, final warnings, referral to treatment or other services, or termination proceedings.
- FSR is not required to use each corrective step or use the steps in a particular order.
- Serious violations may result in immediate protective action and initiation of termination proceedings.

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- A Participant's refusal to sign a warning, corrective-action plan, or other notice does not invalidate the notice. Staff will document the refusal.

14. TERMINATION AND HOUSING

- Housing is provided as part of the Transitional Housing Program and is not provided independently of Program participation.
- Termination from the Transitional Housing Program will end the Participant's eligibility for Program housing and will result in initiation of the process to terminate housing assistance or occupancy. Physical occupancy will end only after FSR follows the applicable lease, sublease, occupancy agreement, required notices, and applicable legal procedures.
- For scattered-site housing, termination from the Transitional Housing Program will end eligibility to remain in the Program-funded unit and will result in initiation of termination under the Participant's sublease. Physical occupancy will end only after required notices and applicable legal procedures are completed.
- Termination of physical occupancy will be implemented through the applicable lease, sublease, occupancy agreement, required notice process, and applicable law.

15. PERSONAL PROPERTY AFTER DEPARTURE

- Participants are responsible for removing their personal belongings when they leave the Program or housing.
- Participants are responsible for removing personal belongings when they leave the Program or housing. FSR will ordinarily hold property left behind for up to 14 calendar days to allow retrieval arrangements, unless a longer period is required by applicable law or approved because the Participant is hospitalized, incarcerated, or has another documented circumstance preventing timely retrieval. Property remaining after the applicable holding period will be handled under FSR's written property procedures and applicable law.
- If a Participant wants another person to retrieve belongings, arrangements must be made in advance with the Case Manager. FSR may require written authorization and identification from the person picking up the property.
- FSR is not required to store property indefinitely. Property remaining beyond the applicable period may be disposed of in accordance with FSR procedure and applicable law.

16. NO WAIVER THROUGH NON-ENFORCEMENT

- Failure by FSR to immediately enforce a Program rule, address a violation, or impose a consequence on one occasion does not waive FSR's right to enforce the same rule in the future.
- An exception, accommodation, or modification for one Participant does not create an exception for another Participant.

PARTICIPANT ACKNOWLEDGMENT

I have received and reviewed the Fifth Street Renaissance Transitional Housing Program Rules. I understand that I am responsible for following these rules and that I must request an approved modification rather than independently disregarding a requirement.

Participant: _____

Signature: _____

Date: _____

FSR Case Manager: _____

Signature: _____

Date: _____

FIFTH STREET RENAISSANCE

INDIVIDUALIZED PARTICIPATION AND SAVINGS PLAN

DOCUMENT 3 OF 3

Participant:	Case Manager:
Program:	Housing Location:
Program Entry Date:	Plan Date:
Next Review Date:	Anticipated Housing Exit Date:

1. INDIVIDUALIZED PROGRAM APPROACH

FSR uses a low-barrier, individualized approach. This plan is developed with the Participant based upon the Participant's strengths, needs, circumstances, barriers, abilities, and permanent-housing goals.

Individualized programming may modify how a requirement is met when appropriate, but a Participant may not create an exception or discontinue a requirement without approval.

2. PERMANENT HOUSING GOAL

Type of permanent housing being pursued:

Preferred location or area: _____

Anticipated relocation date: _____

The relocation date is a planning goal and may be adjusted based upon housing availability, progress, individual circumstances, and continued need for Transitional Housing.

3. BARRIERS TO PERMANENT HOUSING

☐ Income/employment	☐ Credit/debt
☐ Prior eviction/rental history	☐ Criminal/legal history
☐ Identification/documents	☐ Physical health
☐ Mental health	☐ Substance-use treatment/recovery
☐ Transportation	☐ Education/training
☐ Benefits	☐ Childcare/family needs
☐ Housing availability	☐ Independent-living skills
☐ Other: _____	

4. WEEKLY PARTICIPATION PLAN

Standard expectation: at least 20 hours per week of approved activities unless an individualized modification has been approved and documented.

Approved Activity	Planned Hours/Week
Employment	
Job search/employment readiness	
Education/GED/college	
Vocational training	
Substance-use treatment/recovery	
Mental-health services	
Physical-health services related to stability	
Life-skills training	
Housing search/housing preparation	
Case management	
Approved community service	
Court/probation/DCFS requirements	
Benefits/income development	
Other approved activity	
TOTAL	

5. PARTICIPATION MODIFICATION, IF APPLICABLE

- ☐ No modification - standard 20-hour expectation applies
- ☐ Temporary modification approved
- ☐ Ongoing individualized modification approved

Reason for modification: _____

Modified weekly requirement: _____

FIFTH STREET RENAISSANCE

Effective date: _____

Review date: _____

Approved by: _____

6. INCOME AND FINANCIAL RESOURCES

The Participant must report all income and financial resources, including wages, benefits, side work, tips, regular cash gifts or financial support from family or friends, lawsuit or insurance proceeds, inheritances, lump-sum payments, and other money received. Reporting a source does not necessarily mean it will be counted in the occupancy-charge or savings calculation; FSR will determine how the funds are treated under the applicable Program requirements.

Employment income	\$
Benefits/cash assistance	\$
Side work/tips	\$
Regular gifts/support from family or friends	\$
Lump-sum or settlement proceeds	\$
Other income/resources	\$
Total reported monthly recurring income	\$
Other reported nonrecurring resources	\$

7. OCCUPANCY CHARGE

Standard: up to 30% of income, calculated in accordance with the requirements applicable to the Participant's funding source and housing arrangement. If an applicable funding source requires a different calculation or maximum, that requirement controls.

No income = no occupancy charge. FSR does not assess the occupancy charge retroactively for periods during which the Participant had no income.

Verified income used for calculation: _____

Occupancy charge: _____

Effective date: _____

8. REQUIRED SAVINGS PLAN

Standard: 40% of adjusted net income for Participants with income.

No income = no savings requirement. FSR does not require retroactive savings deposits for periods during which the Participant had no income.

Adjusted net income: _____

40% standard savings amount per month: _____

40% standard savings amount per pay period: _____

Current savings balance: _____

FIFTH STREET RENAISSANCE

Target savings at permanent-housing move-in: _____

9. SAVINGS MODIFICATION, IF APPLICABLE

- ☐ No modification - 40% standard applies
- ☐ Modified savings requirement approved

☐ Medical expenses	☐ Childcare
☐ Essential transportation	☐ Court-ordered obligation
☐ Family/household obligation	☐ Temporary income reduction
☐ Necessary debt resolution related to housing stability	☐ Other: _____

Modified amount per month/pay period: _____

Reason/explanation: _____

Effective date: _____

Review date: _____

Approved by: _____

A savings modification remains in effect only for the period approved. The standard 40% requirement resumes at the end of the approved period unless another modification is approved.

10. MONTHLY BUDGET

Expense	Amount
Occupancy charge	\$
Required savings	\$
Food	\$
Transportation	\$
Telephone	\$
Medical	\$
Childcare	\$
Court-ordered obligations	\$
Debt payments	\$
Personal expenses	\$
Other	\$
TOTAL	\$

11. 30-DAY GOALS AND REQUIRED ACTIONS

Goal	Required Actions	Deadline	FSR Assistance

12. HOUSING ACTIVITIES REQUIRED BEFORE NEXT REVIEW

13. OVERNIGHT ABSENCE / SPECIAL SCHEDULING NEEDS, IF APPLICABLE

Planned overnight absences must be approved in advance by the Case Manager. Any recurring work, treatment, family, medical, or other scheduling circumstance that may affect Program participation should be documented here.

14. CASE MANAGER RESPONSIBILITIES

- Provide or coordinate reasonable assistance needed to help the Participant carry out this plan.
- Assist with housing navigation, advocacy, employment and benefits connections, treatment or healthcare linkages, transportation resources, budgeting, life skills, and other appropriate supports.
- Document progress, barriers, missed requirements, approved modifications, and changes to the plan.
- Review the plan with the Participant and adjust individualized goals when circumstances warrant.

15. PARTICIPANT RESPONSIBILITIES

_____ Maintain regular contact with my Case Manager and attend required appointments.

_____ Complete the activities identified in this plan and provide requested verification.

_____ Report all income and financial resources promptly and accurately.

_____ Pay the applicable occupancy charge when I have income; I understand there is no retroactive occupancy charge for a period in which I had no income.

_____ Meet the 40% savings requirement when I have income unless an individualized modification has been approved; I understand savings are not assessed retroactively for a period in which I had no income.

_____ Actively participate in permanent-housing planning and housing-search activities.

_____ Obtain advance Case Manager approval for planned overnight absences.

_____ Follow the alcohol- and drug-free Program requirement, including the prohibition on marijuana/ cannabis.

_____ Discuss barriers with my Case Manager rather than independently stopping or changing a Program requirement.

PLAN ACKNOWLEDGMENT

I participated in developing this plan. I understand that the housing provided to me is part of the Transitional Housing Program and that continued housing is conditioned upon continued Program eligibility and compliance with applicable Program and housing requirements. I understand that individualized programming may modify how I meet a requirement when approved, but does not allow me to independently disregard Program terms or conditions.

Participant: _____

Signature: _____

FIFTH STREET RENAISSANCE

Date: _____

Case Manager: _____

Signature: _____

Date: _____

Program Administrator, if approval is required:

Date: _____



Heartland Continuum of Care 1C-10
Evidence of Coordination and Non-
Interference with Local Efforts to Advance
Protecting Public Safety

Evidence of Coordination and Non-Interference with Local Efforts to Advance Protecting Public Safety	2
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Heartland Encampment Response Protocol

The Heartland Encampment Response Protocol demonstrates how homeless service providers and law enforcement work together in ways that benefit individuals experiencing homelessness, public safety partners, and the broader community. Rather than relying solely on enforcement-driven responses that may simply move individuals from one location to another, the protocol establishes a coordinated approach in which Street Outreach, law enforcement, public health, local government, behavioral health providers, and other community partners each contribute their expertise.

Law enforcement serves as an important partner throughout the process by helping identify encampments and safety concerns, participating in coordinated planning, and supporting safe encampment resolution when necessary. At the same time, Street Outreach and service providers lead engagement with residents, build trust, assess needs, connect individuals with shelter and housing, address behavioral and physical health needs, and work to resolve barriers before an encampment is closed. This approach allows public safety concerns to be addressed while reducing unnecessary enforcement interactions and creating opportunities for longer-term solutions.

The protocol also creates clear communication between law enforcement and service providers so that officers have alternatives and resources available when encountering individuals experiencing homelessness. Alongside partnerships such as SEED and other community initiatives, the HCoC works to ensure that public safety efforts are paired with meaningful access to housing, treatment, shelter, and supportive services. This partnership recognizes that public safety and effective homeless services are complementary goals: connecting people to appropriate resources can improve individual stability, reduce repeated interactions with law enforcement, and create safer, healthier public spaces for the entire community.

Heartland Encampment Response Protocol

OVERARCHING PRINCIPLES

Housing Focused: All actions are oriented toward connecting individuals to permanent housing, not temporary fixes or punitive displacement.

Trauma-Informed: All staff approach with dignity, cultural humility, and awareness of trauma and systemic inequity.

Deep Collaboration: Decisions are made in partnership with community partners, public health, local government, and other stakeholders.

PHASE 1: IDENTIFICATION & REFERRAL

1. Encampment Identification

- **Source:** HCoC Connect App, Heartland HOUSED Street Outreach, Community Relations staff, Public Works, law enforcement, or community members.
- **Collect basic info:** location, size, visibility, urgency, safety risks.

2. Triage and Prioritization

- **Street Outreach Task Group Assesses priority based on:**
 - Number of residents
 - Health and safety risks
 - Proximity to public health hazards (e.g. near a school or heavy traffic)
 - Existing outreach engagement
 - Presence of vulnerable populations (youth, elderly, DV survivors)

3. Internal Coordination

- **Convene an interagency response team:**
 - Heartland HOUSED / HCoC Street Outreach Task Group
 - Local Law Enforcement
 - Service Providers (Helping Hands Shelter, CE Assessors)
 - Behavioral health, substance use services (MBH, ROSC/FGC)
 - City of Springfield (Public Works, Community Relations/Community Care)
 - County (Public Health)
 - Township encampment is located in
 - Lived experience representative (when possible)
 - Additional partners as necessary.

PHASE 2: INITIAL ENGAGEMENT & TRUST BUILDING

4. Outreach Contact

- Within 24–72 hours of referral, conduct a non-enforcement-based visit.
- Introduce services and explain intent: “We are here to support you in finding housing and temporary shelter as quickly as possible.”
- Offer basic needs: water, food, hygiene supplies, naloxone, clothing, etc...
- Build rapport without pressuring or over-promising.

5. Site Assessment

- **Document:**
 - Number of residents and pets
 - Structures (tents, RVs, etc.)
 - Barriers to services (e.g. justice involvement, distrust, lack of ID)
 - Immediate safety hazards (e.g. needles, fire risk, exposed wiring)
 - Services already in use

PHASE 3: HOUSING-CENTERED ENGAGEMENT

6. Comprehensive Outreach

- Assign dedicated case workers for each resident (low caseloads).
- Begin coordinated entry assessments.
- Collect documentation: ID, SSN, income verification, etc.
- Provide transportation to appointments or housing navigation locations.

7. Onsite Services Deployment (as needed)

- Behavioral health and substance use screening
- Medical outreach
- Emergency Shelter outreach to build relationships and share information

8. Develop Individual Housing Plans

- Match each person to appropriate intervention (diversion, shelter, Coordinated Entry).
- Ensure pet-friendly options are considered.

PHASE 4: COORDINATED ENCAMPMENT RESOLUTION

9. Encampment Resolution Planning Meeting

- Once most residents have housing pathways or engaged services:
 - Set a resolution date (this could be a firm date set by a property owner or a goal for resolution set by outreach partners).
 - Clearly and consistently communicate the resolution timeline to residents.
 - Arrange move-out assistance: vehicles, volunteers.
 - Coordinate with public works and law enforcement in a support role.

10. Final Outreach Push (1–2 weeks prior)

- Ensure all residents know the timeline and housing plan.
- Identify remaining barriers: transport, mental health crises, loss of documents, and those unwilling to transition to other solutions.
- Provide emotional and logistical support (peer support and other support avenues).
- Develop a plan to address remaining barriers.

PHASE 5: CLEANUP & POST-RESOLUTION SUPPORT

11. Cleanup Day

- Provide final transport for willing individuals.
- Offer one last outreach opportunity with shelter or housing options.
- Public works clears the site—after voluntary exit or service connection.
- Leave "No Trespassing" signage if necessary or appropriate.

12. Post-Cleanup Follow-Up

- For housed/formerly encamped residents:
 - 30/60/90 day check-ins to support retention
- For those who declined services:
 - Continue street outreach at alternative locations
- Monitor site for re-encampment

DOCUMENTATION & ACCOUNTABILITY

1. Track Outcomes

- Number of people engaged, housed, declined,

- Time from engagement to housing
- Public health data (e.g. primary care connections, narcan distribution)
- Lessons learned

2. Community Debrief

- Conduct a Street Outreach Task Group review of what worked, what didn't.
- Document best practices and update protocols accordingly.
- Share outcomes publicly to build trust and transparency.



Heartland Continuum of Care 1D-1
Local Competition Scoring Tool

Local Competition Scoring Tool (Renewals)	2
Local Competition Scoring Tool (New)	4

HUD FY26 HCOC COC COMPETITION Renewal Project Scoring Tool				
NAME	DESCRIPTION	STATUS	POINTS	SCORE
Coordinated Entry System Participation	The project commits to being a Coordinated Entry access point and maintaining a minimum of one skilled assessor. Housing projects must use CE for 100% of project referrals	Pass/Fail		
HMIS Implementation	The project utilizes the HCOC Homeless Management Information System (HMIS) or comparable database if a victim services provider. Their participation includes quarterly review and timely follow-up to act on Data Quality Management Plan Findings.	Pass/Fail		
Continuum Collaboration	The organization is participating in HCOC Task Groups and Committees that are relevant to the project's goals (such as Street Outreach Task Group, Supportive Housing, Complex Care Committee, etc...)	Pass/Fail		
Nondiscrimination	The project applicant certifies compliance with all applicable nondiscrimination requirements and affirms that it does not use racial preferences or engage in unlawful discriminatory practices.	Pass/Fail		
Harm-Reduction Restriction	The project applicant certifies that it does not operate illegal drug injection sites or "safe consumption sites," knowingly permit the use or distribution of illicit drugs on property under its control, or knowingly distribute drug paraphernalia in violation of applicable federal law.	Pass/Fail		
HUD Threshold Requirements	Project meets requirements for project type found on pages 59-68 of NOFO.	Pass/Fail		
Housing & Supportive Services Policy	Review and monitoring of project policies and procedures to show fidelity to housing with supportive services principles and community standards. (4 points if clear and consistent with practice).		5	5 points
Local Program Monitoring	Review and monitoring of project case notes and assessments to ascertain that participants are being provided with (or linked to) needed services.		5	5 points
Data Quality	The most up to date Data Quality Management Plan Agency Report Score at the time of Rating and Ranking will be used to determine points. Organizations with an agency score of 90% or above will receive 10 points.		10	10 points
Service Participation	Award 5 points if the program will require services if allowed within grant type.		5	5 points
HUD Monitoring Findings	Award 5 points if the project was monitored by HUD but there were no sustained or final negative findings. Award 3 points if the project received negative monitoring findings but the project adequately explains how the findings are being addressed. Award 0 points if the project's monitoring revealed negative findings that have not been corrected. Over the past 24 months from date of competition start. If a project has not been monitored in the past 24 months this scoring metric is not used.	HCOC App	5	Up to 5 points.

HUD FY26 HCOC COC COMPETITION Renewal Project Scoring Tool				
Fiscal Capacity	Award 5 points based on applicant demonstration of sufficient fiscal capacity to manage the grant, including: project budget, internal financial controls, grant match tracking, well-maintained records, oversight by a board of directors, a strategy for documenting eligible costs, a strategy for ensuring adequate grant drawdowns, a recent audit.	Audit Management Letter	5	5 points
Housing Retention (SPM 7)	Count each person who either remained in the project at the end of the measurement period or exited to permanent housing. These are the successes. Then, count the total number of people who participated in the project during the measurement period, excluding people who passed away or who exited to foster care*, nursing homes, or non- psychiatric hospitals or inpatient medical facilities. Divide the number of successes by the number of relevant participants, and apply the scale to the right.	APR Q5 APR Q23	15	≥ 95% = 15 90% - 94.9% = 10 85% - 89.9% = 5 80% - 84.9% = 1 <80% = 0
Employment Income (SPM 4)	Divide the number of successes by the number of relevant participants, and apply the scale to the right.	APR Q5 APR Q16	15	≥ 95% = 15 90% - 94.9% =10 80% - 89.9% = 5 < 80% = 0
Returns to Homelessness (SPM 2)	No more than 15% of exits return to homelessness within 24 months	APR Q23c	10	10 points if no more than 15%
Bed Utilization	Count the average number of people enrolled in the project on the last Wednesday of each quarter, and divide it by the number of beds promised in e-snaps to get the bed utilization rate. Award points based on the scale on the right.	APR Q7b Previous E-snaps App	10	≥ 90% = 10 80% - 89.9% =5 70% - 79.9% = 2 60% - 69.9% = 1 < 60% = 0
Benefit Access	At least 50% of adults increased or maintained noncash benefits.	APR Q20a, APR Q20b	5	5 points if 50% or more
Mental Health and Substance Use Treatment Partnerships	Documented partnerships with healthcare, Community Mental Health Center (CMHC), and Substance Use Treatment providers. Ten points if project has on-site SUD substance use treatment services or maintains a documented formal partnership with a licensed provider who delivers services on-site.		10	
				/ 100 Maximum points

0000002

HUD FY26 HCoC CoC COMPETITION New Project Scoring Tool			
NAME	DESCRIPTION	STATUS	
Coordinated Entry System Participation	The project commits to being a Coordinated Entry access point and maintaining a minimum of one skilled assessor. Housing projects must use CE for 100% of project referrals.	YES/NO	
Continuum Collaboration	The organization commits to participating in HCoC Task Groups and Committees that are relevant to the project's goals (such as Street Outreach Task Group, Supportive Housing, Complex Care Committee, etc..)	YES/NO	
HMIS Implementation	The project will participate in the Homeless Management Information System (HMIS) or comparable database if a victim services provider. This participation includes quarterly review and follow-up to act on Data Quality Management Plan Findings.	YES/NO	
Reporting	Projects must abide by all reporting requirements, including conducting an annual assessment of the service needs of program participants.	YES/NO	
Nondiscrimination	The project applicant certifies compliance with all applicable nondiscrimination requirements and affirms that it does not use racial preferences or engage in unlawful discriminatory practices.	YES/NO	
Harm-Reduction Restriction	The project applicant certifies that it does not operate illegal drug injection sites or "safe consumption sites," knowingly permit the use or distribution of illicit drugs on property under its control, or knowingly distribute drug paraphernalia in violation of applicable federal law.	YES/NO	
Match	The agency has committed to match 25% of the grant award.	YES/NO	
Threshold Criteria	Project meets requirements for project type found on pages 59-68 of NOFO.	YES/NO	
BUDGET, MANAGEMENT, & EXPERIENCE			
Experience with Grants	Award up to 4 points. 1 points for each box checked for Experience with Federal Grants on the HCoC Application reflecting that the agency has: Successfully drawn down at least 95% of funding from a grant of at least \$50,000, Successfully completed a full contract year of a grant from a state or federal government, Prepared detailed timesheets to a funder that showed the hours worked by each staff person each week on different activities and projects, Prepared detailed eligibility documentation to a funder that shows what assistance each client received and why that client was qualified to receive that assistance.	HCoC App	4
HMIS	Award 5 points if the agency had an HMIS license and an employee actively utilizing the system as of June 1, 2026.	HCoC App	5
Participation in CoC Activities	Award points for the agency's attendance and participation at CoC events, Membership meetings, committees, and task groups, with a focus on activities that took place in the past 12 months. 5 points will be awarded if the agency participated in HCoC boards, committees, or task groups and attended over 60% of the meetings in last 12 months. 3 points are awarded if a member of the organization attended 75% of CoC Membership Meetings.	HCoC App	5

HUD FY26 HCOC COC COMPETITION New Project Scoring Tool			
Relevant Experience	Award 5 points if the agency has experience operating at least similar projects, including performance outcome data from similar programs operated by the organization that shows the effects of the services provided. (5 = Extensive or high history/experience is defined as 8+ years, 3 = Some History/experience is defined as 4 to 7 years, 0 = Minimum or No History/Experience is defined as less than 3 years.)	HCoC App	5
Fiscal Capacity	Based on applicant demonstration of having sufficient fiscal capacity to manage the grant, including: project budget, internal financial controls, grant match tracking, match, well-maintained records, oversight by a board of directors, a strategy for documenting eligible costs, a strategy for ensuring adequate grant drawdowns, a recent audit.	HCoC App	5
PROJECT DESIGN			
Homeless System Improvement	Project proposal describes how the project will help improve the performance of the community's overall system, fills a gap/need within our system, move the community forward, and prioritize treatment, recovery, and self-sufficiency for persons with substance abuse disorders, and in achieving HUD and CoC priorities and goals to make homelessness rate, brief and nonrecurring in our CoC. Up to 8 points. (8 = clearly, 4 = somewhat, 0 = inadequately)	HCoC App	8
Project Description: Overview	Award up to 6 points if Project Description describes the overall scope of the project including the clients to be served, which services will be provided and how they will be provided, which partnerships you have to help your clients, and process for quickly assisting clients into permanent housing. (6 = clearly, 3 = somewhat, 0 = inadequately)	HCoC App	6
Project Description: Focus Populations	Award up to 6 points if the Project Description describes the project's proposed populations to be served, including identifying focus(es), and information demonstrating an understanding of the needs of the clients they propose to serve. The description should also clearly identify any populations that will not be served in the project and a rationale for exclusion. (6 = clearly, 3 = somewhat, 0 = inadequately)	HCoC App	6
Projected Measurable Outcomes	Award up to 10 points for outcomes described in application. Outcomes are the primary way for projects to demonstrate effectiveness and impact in effectible ending homelessness. Outcomes based on client accomplishments; not on the number of services/activities provided; demonstrate a positive impact on overall system performance. (10=Outcomes are concise, identified and measurable outcomes that can positively impact overall system performance and are not based on number of activities/services, 5=Outcomes are adequate, but not concise, included some that are based on number of activities/services, and adequately shows positive impact on overall system performance, 0=Outcomes are all based on number of services/activities provided, outcomes are vague, and/or do not demonstrate a positive impact on overall system performance).	HCoC App	10

HUD FY26 HCOC COC COMPETITION New Project Scoring Tool			
Linkage to Appropriate Services	Award up to 5 points if the agency has a clear plan to link clientele with appropriate services to support increasing self-sufficiency. This includes supplementing the project with resources from other private or public sources (e.g. mainstream health, social, and employment programs). The plan details which services are to be provided by the agency, versus those provided via referral to partners. and details how services will be tailored to individual clientele need. (10 = clearly, 5 = somewhat, 0 = inadequately)	HCoC App	10
Service Requirement	HUD has placed a priority on programs that mandate their clients to participate in services. Award up to 5 points based on service requirements. (Project clearly describes and demonstrates how clients will be required to participate in services, including description of services, and a plan for providing services. = 5 points, Project's description is adequate but not thorough, or there is no articulated plan to implement services. = 3 points, Project will not require participation in services. = 0 points) This only applies to Housing projects, not SSO.	HCoC App	5
Treatment and Recovery	HUD has placed a priority on programs that prioritize recovery, treatment, and self sufficiency. Award up to 5 points based on how your project will prioritize treatment, recovery, and self sufficiency for persons with substance abuse disorder. (Project clearly describes and demonstrates how project will prioritize recovery, treatment, and self-sufficiency. = 6 points, Project's description is adequate, but not thorough. = 3 points, Project does not describe or demonstrate how project will prioritize recovery, treatment, and self-sufficiency. = 0 points)	HCoC App	5
Partnership with First Responders and Law Enforcement	Award up to 5 points if the agency demonstrates a history of partnering with first responders and law enforcement to engage people experiencing homelessness and communicates a plan for how this partnership will benefit the project. (5 = history of partnership and collaboration, 3 = plan for partnership, 0 = minimal history or plan). SSO projects only	HCoC App	5
Increasing Employment Income (SPM 4)	Award up to 13 points if the project includes a clear plan for increasing employment income of clients in the program. (13 = clearly, 6 = somewhat, 0 = inadequately)	HCoC App	13
Preventing Returns to Homelessness (SPM 2)	Award up to 13 points if the project includes a clear plan for preventing returns to homelessness by providing services that help clientele obtain and/or maintain housing, focusing on reducing returns to homelessness. (13 = clearly, 6 = somewhat, 0 = inadequately)	HCoC App	13
MAXIMUM POINTS OUT OF 100			100



Heartland Continuum of Care 1D-2C
Local Competition Selection Results

Local Competition Selection Results 2



Heartland Continuum of Care 2A-8B
FY 2026 HDX Competition Report

FY 2026 HDX Competition Report	2
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2026 Competition Report - Summary

IL-513 - Springfield/Sangamon County CoC

HDX Data Submission Participation Information

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

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

2026 Competition Report - LSA Summary & Usability Status

IL-513 - Springfield/Sangamon County CoC

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

LSA Usability Status 2025

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

Glossary: EST = Emergency Shelter, Save Haven, & Transitional Housing; RRH = Rapid Re-housing; PSH = Permanent Supportive Housing; AO = Persons in Households without Children; AC = Persons in Households with at least one Adult and one Child; CO=Persons in Households with only Children

*Usability was not determined for PSH-AC due to built-in conflicts between HOMES and HMIS. As such, this category is marked "not applicable" (N/A) for every CoC.

2026 Competition Report - SPM Data

IL-513 - Springfield/Sangamon County CoC

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

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than the look back stop date or client's date of birth, whichever is later.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.

Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, and SH	1,314	62.2	29.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	1,529	109.0	47.0

b. This measure is based on data element 3.917

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

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, SH, and PH (prior to “housing move in”)	1,366	381.2	130.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	1,576	392.0	161.0

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

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

		Total # of Persons Exited to a PH Destination (2 Yrs Prior)	Returns to Homelessness in Less than 6 Months (0 - 180 days)	Returns to Homelessness from 6 to 12 Months (181 - 365 days)	Returns to Homelessness from 13 to 24 Months (366 - 730 days)	Number of Returns in 2 Years				
Metric	Count	Count	% of Returns	Count	% of Returns	Count	% of Returns			
Exit was from SO	7	1	14.3%	1	14.3%	2	28.6%	4	57.1%	
Exit was from ES	134	31	23.1%	7	5.2%	9	6.7%	47	35.1%	
Exit was from TH	113	11	9.7%	2	1.8%	14	12.4%	27	23.9%	
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%	
Exit was from PH	80	6	7.5%	1	1.3%	18	22.5%	25	31.3%	
TOTAL Returns to Homelessness		334	49	14.7%	11	3.3%	43	12.9%	103	30.8%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

Please refer to PIT section for relevant data.

Metric 3.2 – Change in Annual Counts

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

Metric	Value
Universe: Unduplicated Total sheltered homeless persons	1,531
Emergency Shelter Total	1,316
Safe Haven Total	0
Transitional Housing Total	291

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

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

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

Metric	Value
Universe: Number of adults (system stayers)	29
Number of adults with increased earned income	3

Percentage of adults who increased earned income	10.3%
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Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

Metric	Value
Universe: Number of adults (system stayers)	29
Number of adults with increased non-employment cash income	1
Percentage of adults who increased non-employment cash income	3.5%

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

Metric	Value
Universe: Number of adults (system stayers)	29
Number of adults with increased total income	4
Percentage of adults who increased total income	13.8%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	42
Number of adults who exited with increased earned income	3

Percentage of adults who increased earned income	7.1%
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Metric 4.5 – Change in non-employment cash income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	42
Number of adults who exited with increased non-employment cash income	7
Percentage of adults who increased non-employment cash income	16.7%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	42
Number of adults who exited with increased total income	9
Percentage of adults who increased total income	21.4%

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

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

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

Metric	Value
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Universe: Person with entries into ES-EE, ES-NbN, SH or TH during the reporting period.	1,430
Of persons above, count those who were in ES-EE, ES-NbN, SH, TH or any PH within 24 months prior to their entry during the reporting year.	351
Of persons above, count those who did not have entries in ES-EE, ES-NbN, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	1,079

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

Metric	Value
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	1,521
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	396

Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	1,125
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Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

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

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

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

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

Metric	Value
Universe: Persons who exit Street Outreach	215
Of persons above, those who exited to temporary & some institutional destinations	35
Of the persons above, those who exited to permanent housing destinations	56

% Successful exits	42.3%
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Metric 7b.1 – Change in ES, SH, TH, and PH-RRH exits to permanent housing destinations

Metric	Value
Universe: Persons in ES-EE, ES-NbN, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	1,312
Of the persons above, those who exited to permanent housing destinations	332
% Successful exits	25.3%

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

Metric	Value
Universe: Persons in all PH projects except PH-RRH who exited after moving into housing, or who moved into housing and remained in the PH project	168
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	158

% Successful exits/retention	94.1%
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System Performance Measures Data Quality

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

Metric	All ES, SH	All TH	All PSH, OPH	All RRH	All Street Outreach
Unduplicated Persons Served (HMIS)	1,414	291	199	151	171
Total Leavers (HMIS)	1,237	186	70	63	133
Destination of Don't Know, Refused, or Missing (HMIS)	0	1	0	0	92
Destination Error Rate (Calculated)	0.0%	0.5%	0.0%	0.0%	69.2%

2026 Competition Report - SPM Notes
IL-513 - Springfield/Sangamon County CoC
FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

Notes For Each SPM Measure

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

2025 HDX Competition Report

2026 Competition Report - HIC Summary
IL-513 - Springfield/Sangamon County CoC
For HIC conducted in January/February of 2026

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current Non-VSP Beds In HMIS or Comparable Database	Total Year-Round, Current, Non-VSP Beds	Removed From Denominator: OPH EHV+ Beds or Beds Affected by Natural Disaster**	Adjusted*** Total Year-Round, Current, Non-VSP Beds	Adjusted*** HMIS Bed Coverage Rate for Year-Round, Current Beds	Total Year-Round, Current, VSP Beds in an HMIS-Comparable Database	Total Year-Round, Current, VSP Beds	Removed From Denominator: OPH EHV+ Beds or Beds Affected by Natural Disaster**	Adjusted*** Total Year-Round, Current, VSP Beds	HMIS Comparable Bed Coverage Rate for VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS-Comparable Database	Adjusted*** Total Year-Round, Current, Non-VSP and VSP Beds	HMIS and Comparable Database Coverage Rate
ES	273	240	240	0	240	100.0%	33	33	0	33	100.00%	273	273	100.00%
SH	0	0	0	0	0	NA	0	0	0	0	NA	0	0	NA
TH	151	151	151	0	151	100.0%	0	0	0	0	NA	151	151	100.00%
RRH	97	65	97	0	97	67.0%	0	0	0	0	NA	65	97	67.01%
PSH	322	291	322	0	322	90.4%	0	0	0	0	NA	291	322	90.37%
OPH	36	0	36	36	0	NA	0	0	0	0	NA	0	0	NA
Total	879	747	846	36	810	92.2%	33	33	0	33	100.00%	780	843	92.53%

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

2026 Competition Report - PIT Summary

IL-513 - Springfield/Sangamon County CoC

For PIT conducted in January/February of 2026

Submission Information

Date of PIT Count	Received HUD Waiver
1/21/2026	Not Applicable

Total Population PIT Count Data

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Emergency Shelter Total	257	225	276
Safe Haven Total	0	0	0
Transitional Housing Total	105	136	102
Total Sheltered Count	362	361	378
Total Unsheltered Count	26	13	21
Total Sheltered and Unsheltered Count*	388	374	399

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

Total People Experiencing Chronic Homelessness

2025 HDX Competition Report

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Total Sheltered Count	63	62	83
Total Unsheltered Count	15	4	10
Total	78	66	93



Heartland Continuum of Care 3A-1
HUD-2996 Certification for Opportunity
Zone Preference Points

HUD-2996 Certification for Opportunity Zone Preference Points 2

**Certification for Opportunity Zones
Preference Points**

**U.S. Department of Housing and
Urban Development**

OMB Number: 2501-0044
Expiration Date: 02/28/2027

Type or clearly print the following information.

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

Applicant Organization: Heartland Housed

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

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

14.267 Continuum of Care (COC) Program

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

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

17167001300; 17167000800; 17167000900; 17167001600; 17167001700; 17167002400; 17167002500

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

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

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

Estimated Funding Allocations

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

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

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

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

Heartland Continuum of Care projects funded through HUD's Continuum of Care program will provide individuals and families in the Opportunity Zone with Permanent Supportive Housing, Transitional Housing, and Supportive Services. Together these programs will work to effectively address homelessness within the opportunity zone.

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

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

Certification of Authorized Representative for the Applicant:

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

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

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

Title:
Organization:
Signature:
Date:



Heartland Continuum of Care 3A-DP
CoC's Policy or Statement to Advance
Recovery

Your CoC's Policy or Statement to Advance Recovery 2



Prohibitions: In alignment with the FY2026 CoC NOFO, projects funded by HUD are prohibited from:

- Operating drug injection sites or safe consumption sites;
- Knowingly distributing drug paraphernalia¹ on or off property under their control; or
- Knowingly permitting the use of distribution of illicit drugs on property under their control.

The activities outlined above will not be conducted, permitted, encouraged, or allowed, even within the context of harm reduction.

Violations: CoC-funded housing projects determined to be in violation of the above are required to participate in technical assistance to resolve the violations and prevent future violations of this statement. If the CoC-funded housing project in violation does not participate in the technical assistance, their program may face a transfer or reallocation in the next NOFO cycle if they are unwilling to participate in TA and take the necessary actions to become compliant with the statement.

Program Policies & Resources: To be clear, this CoC statement does **not** require that projects condition assistance on sobriety or treatment participation (but projects may, in accordance with 24 CFR 578) or that participants be evicted or exited from assistance for a first-time violation of a drug-related program policy or lease requirement.

CoC-funded housing projects should continue to support clients with substance use disorders through partnerships with behavioral health providers, substance use disorder treatment providers, community groups, and recovery-oriented resources (e.g., recovery housing). This support should be client-centered and focused on maintaining safe and stable housing.

For Additional Information: If you have questions about how this statement applies to your CoC-funded housing project, please reach out to Heartland HOUSED.

¹ Our CoC understands “drug paraphernalia,” as defined in the April 24, 2026 SAMHSA Dear Colleague letter, available at: <https://www.samhsa.gov/sites/default/files/dear-colleague-letter-updated-hr-funding-guidance.pdf> to include:

- Syringes or needles used to inject illicit drugs
- Pipes or other supplies for safer smoking kits
- Fentanyl test strips or any other substance test kits, including xylazine and medetomidine test strips, intended for use by people using drugs
- Sterile water, saline, or ascorbic acid (vitamin c) used to facilitate drug use
- Any other drug paraphernalia or supplies that promote or facilitate drug use not listed as acceptable above