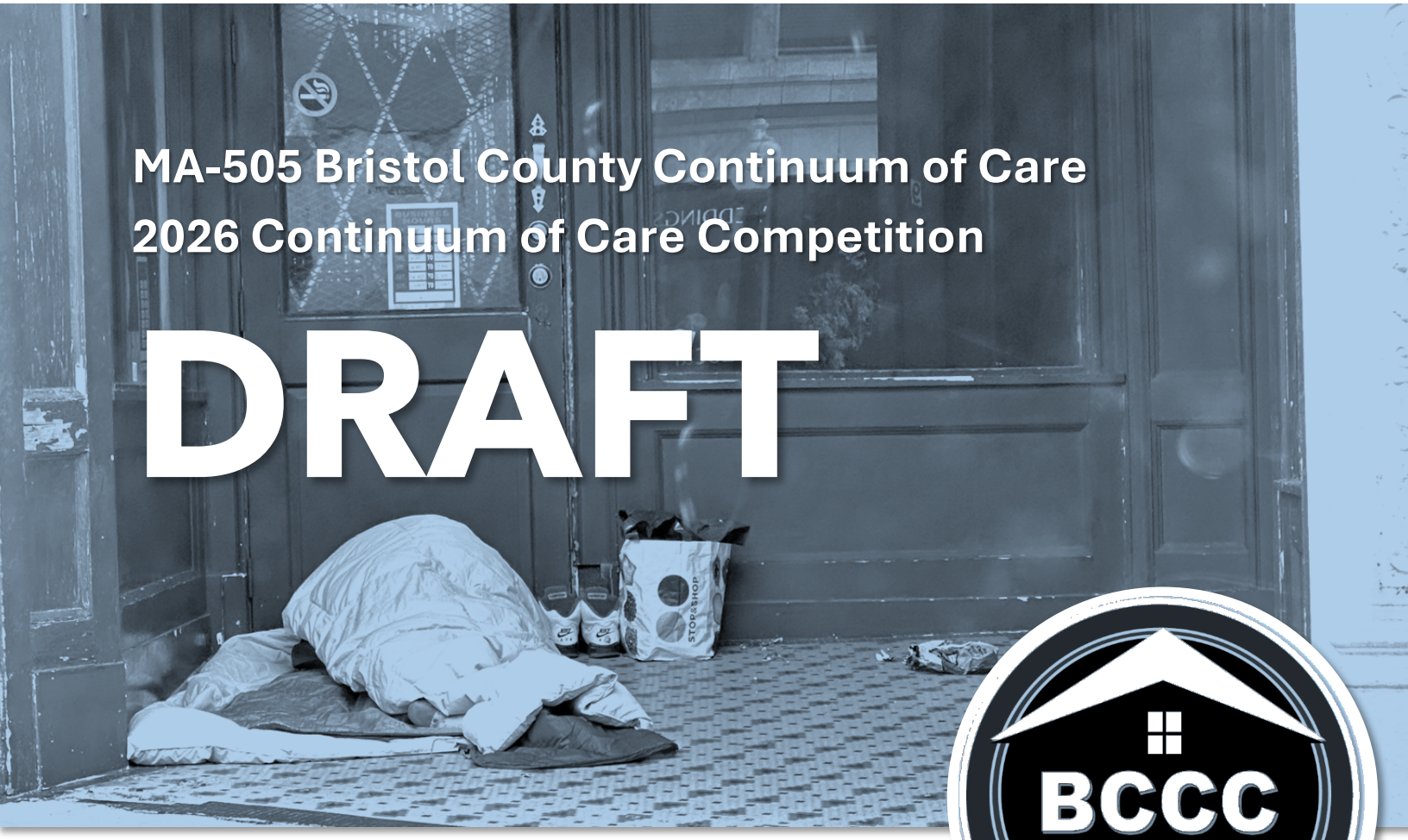

MA-505 Bristol County Continuum of Care
2026 Continuum of Care Competition

DRAFT

CoC Application

For the MA-505 Bristol County CoC

This document constitutes part 1 of a multi-part application to the U.S. Department of Housing & Urban Development's 2026 CoC Competition

This document is the CoC Application

Draft version posted: September 25, 2026

These are part of the DRAFT MA-505 Consolidated Application materials; this and all competition materials are available at **www.bristolcountycoc.com** website.

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: MA-505 - New Bedford, Attleboro, Taunton/Bristol County CoC

1A-2. Collaborative Applicant Name: City of New Bedford

1A-3. CoC Designation: CA

1A-4. HMIS Lead: City of New Bedford

1B. Coordination and Engagement–Accountable Structure and Participation

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

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

1B-1.	Accountable Structure and Participation.	

	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)	Yes	1
4.	Community Mental Health Center (CMHC)	Yes	1
5.	Disability Advocate(s)	Yes	1
6.	Disability Service Organization(s)	Yes	
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	1
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	1
9.	Faith-based Organzation(s)	Yes	2
10.	Homeless or Formerly Homeless Person(s)	Yes	2
11.	Hospital(s)	Yes	2
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	1
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	No	
14.	Law Enforcement	Yes	
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	
16.	Local Government Staff/Official(s)	Yes	1

17.	State Government Staff/Official(s)	Yes	1
18.	State or Local Elected Public Official(s)	No	
19.	Local Jail(s)	Yes	
20.	Mental Health Service Organization(s)	Yes	1
21.	Mental Illness Advocate(s)	Yes	1
22.	Organization(s) led by and serving people with disabilities	Yes	
23.	Other homeless subpopulation advocate(s)	Yes	1
24.	Other nonprofit homeless assistance provider(s)	Yes	1
25.	Other social service provider(s)	Yes	1
26.	Public Housing Agencies	Yes	1
27.	Recovery Housing or Sober Living Provider(s)	Yes	1
28.	School Administrators/Homeless Liaison(s)	Yes	1
29.	School District(s)	Yes	
30.	Street Outreach Team(s)	Yes	1
31.	Substance Abuse Advocate(s)	Yes	1
32.	Substance Abuse Service Organization(s)	Yes	1
33.	Universities	No	
34.	Veteran Serving Organization(s)	Yes	
35.	Agencies Serving Survivors of Human Trafficking	Yes	1
36.	Victim Service Provider(s)	Yes	1
37.	Domestic Violence Advocate(s)	Yes	1
38.	Other Victim Service Organization(s)	Yes	1
39.	State Domestic Violence Coalition	No	
40.	State Sexual Assault Coalition	No	
41.	Youth Advocate(s)	Yes	
42.	Youth Homeless Organization(s)	No	
43.	Youth Service Provider(s)	Yes	1
44.	Other Homeless Assistance Provider(s)	Yes	1
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	
	Other: (limit 50 characters)		
46.	CONGRESSIONAL OFFICE/KEATING MA-09	Yes	1
47.	WORKFORCE/CAREER DEVT CENTER	Yes	1

1B-2.	Open Invitation for New Members.	

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

(limit 2,500 characters)

MA-505 CoC's invitation process solicits new members is transparent, publicly available within the CoC and is communicated annually in multiple ways:
a. Direct outreach through personal contacts, shelters and street outreach efforts extends an invitation to those with lived experience/expertise.
b. Notice is placed on the CoC's website inviting/encouraging new members. The website post reinforces the welcoming of renewal members and those who have never applied/joined.
c. Targeted emails connect membership opportunities with a range of community groups including employment/career centers, those serving law enforcement, faith and education communities, seniors and disabled populations, local and state government officials, local businesses etc. Additional invitations are made through social media and via outreach to other coalitions within the CoC. Emphasis is placed on welcoming those interested in ending homelessness and affecting change to the housing crisis.
d. CoC members and those attending CoC meetings are asked to encourage new members from the community to join the CoC throughout the year to ensure inclusion of a broad, diverse and expanding membership. This is a fixed item on each agenda.
e. In all its outreach, its website and on its application form, the CoC makes clear that membership is always FREE and accessible, and therefore available to all.

The invitation process for a calendar year membership begins in January and is open and offered all 12 months of the year.

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

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

(limit 2,500 characters)

The MA-505 CoC maintains an open, transparent, community-based process to solicit and consider input on the CoC's performance, strategies, and priority-setting from a broad array of stakeholders. This process is communicated to the public via the CoC website, email, public meeting notices, and community forums.

Soliciting and Considering Input: The CoC holds open monthly CoC meetings and planning activities that are publicly accessible, providing consistent opportunities for feedback from providers, people with lived experience, government agencies, and community members. Input is gathered year-round through meetings, surveys, focus groups, public forums, and targeted consultations, and is incorporated into strategic planning, system improvements, and funding priorities. During its most recent strategic planning process, the CoC engaged the Technical Assistance Collaborative (TAC) to conduct focus groups with people experiencing homelessness and surveys of providers and stakeholders; this input directly informed major system changes, including the 2024 merger of MA-505 and MA-519, as well as ongoing system improvements and funding decisions.

Range of Stakeholders Engaged: CoC engages a broad cross-section of individuals and organizations with knowledge of or interest in homelessness, including homeless service providers; people with lived experience; public housing authorities; municipal and state agencies; behavioral health and health care providers; veterans' organizations; faith-based and community organizations; advocates; and other public and private partners. The CoC also participates in broader community forums addressing vulnerable populations to extend its reach.

Accessibility: To ensure meaningful participation, including from those facing barriers, the CoC provides ADA-compliant digital access, closed captioning for virtual meetings, and additional accommodations and support as needed.

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

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

(limit 2,500 characters)

The CoC accepts and considers proposals through a transparent, publicly announced local NOFO competition. The CoC publicly announces the competition, availability of the local project application, submission deadline, and its acceptance of project proposals through the City of New Bedford and CoC websites, social media, and direct outreach to community organizations, including the faith-based community and DV providers. The CoC specifically encourages organizations that have not previously applied to participate. Interested organizations are invited to contact the CoC Collaborative Applicant for information and assistance. The local application provides detailed instructions for submitting project applications and explains the CoC's project selection, scoring, ranking, reallocation, and appeal processes. Projects selected for submission to HUD receive additional guidance regarding e-snaps submission. The CoC also ensures effective communication and access for persons with disabilities by providing the local application information on an ADA-compliant website, in screen-reader-compatible formats, and upon request, through PDF and fillable application formats.

The CoC actively conducts outreach to organizations that have not previously received CoC Program funding. In addition to public notification, the CoC directly distributes information about the competition and encourages organizations unfamiliar with the CoC funding process to contact the Collaborative Applicant for assistance. Outreach is specifically directed to organizations who have previously not sought funding through the CoC Competition including non-housing entities that provide outreach services and supports consistent with HUD priorities. The CoC's public notices clearly state that the competition is open to eligible applicants and that organizations do not need to have previously applied for CoC funding to submit a proposal. These efforts are intended to ensure that organizations new to the CoC funding process have meaningful access to information and an opportunity to participate.

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

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

(limit 2,500 characters)

The MA-505 CoC uses HMIS, PIT/HIC data, System Performance Measures, and stakeholder and lived-experience input to identify gaps and drive data-driven, success-focused strategies. In 2024, The CoC retained the Technical Assistance Collaborative (TAC) to conduct a system assessment using HMIS/LSA and PIT/HIC data, surveys, focus groups, and provider/stakeholder interviews.

Gap Identified: The assessment identified rising unsheltered homelessness alongside gaps in housing access, Coordinated Entry, diversion/prevention, outreach, and system coordination.

Comprehensive Strategy: To close this gap, the CoC continues to implement interventions consistent with 42 U.S.C. 11386b(d): strengthening Coordinated Entry and housing navigation; expanding diversion/prevention to resolve crises before shelter entry; enhancing street outreach; increasing permanent supportive housing for people experiencing chronic homelessness; and improving coordination with mainstream housing and health systems. Responses are tailored to families, veterans, youth, survivors of domestic violence, and people with disabilities.

Realignment for Results: In this NOFO round, the MA-505 CoC is realigning its funding toward these evidence-based priorities, reallocating lower-performing projects into focused, success-oriented interventions that directly target the identified gap and maximize measurable outcomes consistent with HUD priorities.

Performance & Accountability: Progress is tracked via PIT/HIC trends, System Performance Measures, Coordinated Entry data, housing placements, exits to permanent housing, returns to homelessness, and reductions in unsheltered/chronic homelessness. Benchmarks are set in the CoC's Written Standards, with progress reviewed via annual PIT/HIC and NOFO cycles to adjust investments. Activities are funded through CoC, ESG, other federal, state, local, and mainstream resources. New Bedford's OHCD, as Collaborative Applicant, provides administrative support; the CoC's Executive Board and Performance Review Committee oversee implementation, monitoring, and system improvement.

1B-5a	Confirmation of Plan Coverage.

Select 'Yes' or 'No' in the chart below to indicate whether your narrative in question 1B-5 addresses the following aspects of your plan to address a gap in the CoC's current homelessness system.	
1. Identifies the gap, using data or stakeholder feedback	Yes
2. The strategy to address the needs of all relevant subpopulations	Yes
3. Sets quantifiable performance measures	Yes
4. Identifies timelines for the completion of specific tasks	Yes
5. Identifies specific funding sources for planned activities	Yes

6. An individual or body responsible for overseeing implementation of specific strategies	Yes

1C. Coordination and Engagement

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?	75%

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

(limit 2,500 characters)

N/A

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

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

(limit 2,500 characters)

The MA-505, a merged CoC (MA-505 + MA-519) of over 60 member organizations, partners with multiple providers to ensure participants can access outpatient mental health and substance use treatment across a full range of care opportunities. Community Counseling of Bristol County (also a CCBHC) operates the CoC's coordinated Entry and delivers outpatient behavioral health across Bristol County. High Point Treatment Center provides a variety of opportunities for treatment and is often the first step toward sobriety with their inpatient detoxification services. Once an individual has completed detox (not all with substance use issues have to complete detox but at times it is medically necessary) they are able to begin working with programs that provide outpatient services, recovery coaching and recovery navigators. These programs are offered at CCBC, High Point, PAACA, and Steppingstone.

Other programs and agencies throughout the Continuum in addition to those above provide assistance specifically for Serious Mental Illness and Co-Occurring Disorders. Stimulate Treatment and Recovery Team (START) provides a walk in clinic where services are immediately available as does the New Bedford Behavioral Health Urgent Care, Child and Family Services, and CCBC's walk in clinics. Psychiatric medications including long acting injectable psychiatric medications are provided at most of the agencies listed above as well to ensure the best opportunity for long term success. High Point also acts as a Children's Behavioral Health Initiative (CBHI) partner. This provides in home behavioral healthcare for children and adults.

Once someone has begun their recovery journey it is important for them to access appropriate social spaces which will assist with further job training, recovery, and learning how to engage in the community more positively. Peer centers exist in both New Bedford and Taunton to create these atmospheres. Rise and the Taunton Peer Center are designed to complement, not replace, clinical treatment: peer staff build trust and lived-experience rapport that helps engage individuals who are hesitant to enter transitional behavioral health settings, then navigate them toward appropriate outpatient, crisis, or housing-based services within the CoC's network.

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)

The MA-505 CoC partners with, and counts among its membership, agencies that embed certified peer recovery specialists and recovery navigation directly into services for people experiencing homelessness.

Community Counseling of Bristol County (CCBC), the CoC's Coordinated Entry lead agency, operates the Taunton Peer Recovery Support Center and employs CARC-certified Recovery Coaches who work one-on-one with adults with substance use and co-occurring disorders. Coaches help clients build recovery plans, set short-term goals, develop relapse-prevention strategies, and connect to community, wellness, and recovery resources. CCBC's Recovery Coaches are integrated into multi-disciplinary teams alongside outpatient clinical and mobile crisis services and accompany clients to appointments and mutual-support meetings (e.g., AA, faith-based groups) to strengthen engagement. CCBC also operates a dedicated Recovery Support Navigator role to help participants move between levels of care and community supports. Steppingstone, Inc. is another key partner, offering Recovery Coaching, Recovery Support Navigation, and Community Support Services alongside intensive case management and care coordination for individuals with substance use disorders, including those with co-occurring HIV/AIDS.

These peer-delivered services are designed to complement, not replace, clinical treatment: peer staff build trust and lived-experience rapport that helps engage individuals who are hesitant to enter traditional behavioral health settings, then navigate them toward appropriate outpatient, crisis, or housing-based services within the CoC's network.

Most of the CoC projects including Steppingstone, PAACA, SEMCOA, and CCBC projects employ staff with lived experience, often trained as recovery specialists. This aids in quick access to treatment and follow up for those in the programs as these staff can more effectively navigate the treatment and recovery system.

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 MA-505 CoC identifies individuals with Serious Mental Illness (SMI) through a variety of avenues including Coordinated Entry through CCBC, Steppingstone's street outreach program, as well as walk in behavioral health centers such as Child and Family Services, New Bedford Behavioral Health Urgent Care, High Point outpatient services, and CCBC's walk in center, additionally there are two crisis services providers within the CoC. Through Case conferencing which includes the MA Department of Mental Health the Continuum is able to triage and assist those with SMI access the most appropriate treatment.

Once identified, the CoC connects individuals and families to intensive, team-based models rath that standard outpatient care alone. HighPoints' Children's Behavioral Health Initiative provides care in the home and community to best service those who need care in their community. CCBC operates a PACT (Program of Assertive Community Treatment) teams throughout the continuum delivering 24/7/365 multidisciplinary treatment, rehabilitation and support to people with SMI who are enrolled in the Department of Mental Health. Additionally CCBC's and Child and Family Services' Mobile Crisis Intervention and Crisis Stabilization units provide rapid in the moment response for individuals in acute psychiatric crisis, reducing avoidable Emergency Department visits and hospitalization.

In the SouthCoast area of the CoC project FAIHR, operated through Steppingstone Inc. works through the outreach team to identify those with SMI, and provides access to therapy and prescribers within the program. This is a key component to comprehensive treatment in the area allowing for those unhoused to connect to services in a safe environment.

All of the programs noted here as well as others throughout the CoC work collaboratively to ensure access to treatment whether it be in the community or though hospitalization and then aftercare when necessary.

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

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

(limit 500 characters)

The CoC partners with Community Crisis Intervention Teams (CCIT) in New Bedford and Taunton, bringing CoC providers together with law enforcement, behavioral health professionals, courts, and community agencies to respond to individuals experiencing mental health and substance use crises. CCIT facilitates diversion from incarceration/ hospitalization, coordinated referrals, treatment connections, and housing stabilization for individuals who are homeless or at risk of homelessness.

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

(limit 2,500 characters)

The CoC maintains active coordination with both the Taunton and Greater New Bedford Community Crisis Intervention Teams (CCIT), law enforcement, courts, probation, corrections, behavioral health providers, and community-based organizations to promote housing stability, treatment engagement, recovery, and self-sufficiency. Through regular CCIT collaboration and case coordination in these key population centers within the CoC, partners identify individuals experiencing homelessness or at risk, address barriers to housing, and connect them with appropriate housing, treatment, employment, benefits, and supportive services. The CoC actively works with courts and probation to align housing and service plans with court requirements and, when applicable, leverage court orders to reinforce treatment participation, accountability, and connection to services.

This coordinated approach provides individuals with clear expectations, consistent support, and a pathway toward stable housing and greater independence while promoting public safety and responsible use of community resources.

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 MA-505 CoC partners with Child & Family Services (CFS), the New Bedford-area crisis provider, to connect people experiencing or at risk of homelessness with 988 and 24/7 crisis response, including mobile crisis intervention, behavioral health assessment, stabilization, and follow-up services. CoC providers coordinate with CFS to address immediate crises while connecting individuals to housing, treatment, benefits, and ongoing supports, helping prevent crisis escalation and housing loss.

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.	37

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

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

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

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

(limit 500 characters)

The CoC has entered into an MOU with Community Counseling of Bristol County CCBC, the largest provider of mental health services in the CoC to work cooperatively with their programs including the CCBHC and CMHC projects to ensure those within the CoC have access to services and training to ensure the most effective care available.

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

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

(limit 500 characters)

The Step Up PSH, a current CoC project operated by PAACA and the PAACA-proposed project Recovery Works both offer sober housing environments for those who need the ongoing accountability for substance use issues. These are essential for the success of the CoC offering a variety of housing projects to meet the needs of the community. Other projects will offer treatment and progress toward self sufficiency, holding participants accountable in moving forward.

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

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

(limit 2,500 characters)

The MA-505 CoC maintains active partnerships with outpatient mental health and substance use disorder clinics—including AdCare, Child & Family Services, Community Counseling of Bristol County (CCBC), Comprehensive Treatment Center, HighPoint, Northeast Health Center, Steppingstone's licensed outpatient MH/SUD clinics, Southcoast Health, and SSTAR—to ensure participants moving into stable housing keep uninterrupted access to clinical care. Housing case managers make in-person introductions to these providers, and with participant consent, review needs, goals, and available resources directly with the treatment team so services follow the person into their new housing rather than starting over.

For Peer Support and Recovery Navigation, case managers pair participants with wrap-around voluntary services and peer navigators who assist with financial literacy and budget planning, transportation assistance when funding allows, and connections to community resources. Peer staff help participants place initial and follow-up calls or attend in-person appointments to obtain services, and support participants in creating self-directed goal plans, building the participant's own capacity to sustain housing and recovery.

To connect individuals experiencing serious mental illness with services necessary for stability, staff confirm that all needed services are in place before and after move-in, making new referrals as gaps are identified. Staff assist participants in understanding and signing leases, coordinate moving assistance for furniture and belongings, and communicate directly with the receiving housing provider to facilitate a smooth handoff. Case managers coordinate with landlords, housing authorities, subsidized housing providers, and permanent housing providers throughout the transition.

Across all three services, the CoC's approach centers on relationship-building: housing teams cultivate trust with local landlords and housing providers, which expands opportunities for participants to move from supportive housing into independent stable housing. Ongoing MassHealth-funded case management continues after move-in, allowing staff to intervene early if instability arises. Participants are encouraged to remain in contact with program staff post-exit, and providers offer continued support as needed—creating a coordinated safety net that connects treatment, peer recovery, and housing systems to prevent housing loss and re-entry into homelessness.

1C-2.	Supportive Services Investment.	

	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	$3,847,594
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.	$1,008,446
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	26%

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.	$252,112
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).	33%

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)?	50.00%

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 MA-505 CoC maintains an integrated, ongoing consultation process with ESG recipients that is structurally embedded rather than incidental. The Collaborative Applicant, the City of New Bedford, is itself an ESG entitlement recipient and administers ESG allocations directly. This dual role means CoC planning and ESG administration are not separate silos: the same staff and governance structure overseeing CoC strategy also oversee ESG subrecipient contracting, monitoring, and reporting, ensuring funding decisions are informed by real-time, on-the-ground data rather than periodic or arms-length input.

ESG subrecipients participate in CoC planning through board and committee representation, coordinated entry workgroups, and required adherence to the CoC's written standards and prioritization policies. Beyond formal meetings, the City's ongoing contract monitoring of ESG subrecipients—site visits, HMIS data review, expenditure and outcomes tracking—generates continuous insight that directly shapes CoC decision-making.

This monitoring has surfaced trending client-level challenges, including rising co-occurring mental health and substance use presentations among people seeking shelter and prevention assistance, informing the CoC's prioritization of services-intensive interventions and referral pathways.

It has also revealed systemic, structural barriers driving local inflow into homelessness: landlords increasingly screening out applicants with poor credit history regardless of voucher eligibility; a shrinking share of rental units priced at or below Fair Market Rent; housing pressure connected to immigration and migration into the CoC, straining an already limited affordable stock; and persistently low vacancy rates that leave few viable exit destinations even when subsidy is available.

This data feeds directly into the CoC's gaps analysis and annual planning priorities informing joint CoC/ESG decisions on resource allocation, diversion strategies, and landlord engagement. The CoC and City are also working to align ESG-funded prevention and rapid re-housing with coordinated entry, strengthen data-sharing so ESG performance metrics inform system-level performance review, and use this combined dataset to shape the City's Consolidated Plan and future NOFO strategy—a feedback loop where ESG implementation continuously refines CoC-wide planning, not a one-time consultation exercise.

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

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

(limit 2,500 characters)

The CoC works closely with the local emergency shelter providers, both for families and individuals. The Executive Board includes the CEO of the local shelter provider for all individual shelters in the continuum. Additionally, the only family shelter provider in the area is an active participant in the continuum as is the CEO of the VSP offering shelter for survivors.

The Coordinated Entry Team (CET) meets at the shelter locations regularly throughout the CoC to ensure each client is entered into the CoC system and has access to all housing, treatment, mainstream resource, as well as job training and educational opportunities available. Working collaboratively with shelter case managers, each client can begin making progress toward self sufficiency. The CET works to ensure clients have access to treatment, transitional housing, permanent supportive housing, or ESG funds for rapid rehousing in market rate units as available.

Through case conferencing the CET is able to assess each family and individual to help determine the level of care and type of housing that gives the client the highest opportunity for success. With the addition of more transitional housing programs, this will open the door for opportunities for those who may need more treatment focused work to access temporary housing while working through issues of substance use and untreated mental health barriers.

The emergency shelter providers also participate in the By Name List meetings, ensuring the CET has the most up to date information on someone's progress and help determine the best course of action for someone to be successful and not return to homelessness.

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

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

(limit 2,500 characters)

The MA-505 regularly shares its HMIS data with the Commonwealth of Massachusetts through regular monthly uploads of de-identified data into a statewide system. The Massachusetts Rehousing Data Collective (RDC) is a centralized statewide database designed to aggregate and warehouse data regarding homelessness and housing instability across the Commonwealth. Developed by the Massachusetts Interagency Council on Homelessness and operated under the Executive Office of Housing and Livable Communities (EOHLC), the RDC acts as a unified data center to resolve the issue of siloed information across different geographical regions. The MA-505 electronically uploads all of its data into that system and works with the state's RDC administrators to ensure the highest data quality on an ongoing basis. Additionally, the CoC provides data to local municipalities as requested and perhaps most significantly, it provides an easily accessible online data dashboard providing system performance data (https://www.bristolcountycoc.com/bristol-county-coc-cmmunity-performance-dashboard/). Lastly, the CoC also shares its PIT and HIC data annually with the public and provides a PowerPoint deck with specific PIT/HIC data and trending analysis on its website, the most recent of which is at https://www.bristolcountycoc.com/2026-pit-and-hic-data-presentation/.

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 MA-505 Continuum of Care (CoC) uses HMIS as the primary system for coordinating homeless services while incorporating information from other systems, when permitted by applicable law, client consent, and data-sharing agreements, to better understand client needs and coordinate care. These sources include health care and behavioral health information, hospital admission/discharge information, and information from justice-system partners. Through partnerships with local Community Crisis Intervention Teams (CCIT) health care providers, behavioral health agencies, hospitals, law enforcement, courts, and corrections partners, the CoC uses available data to identify individuals with repeated or high levels of service utilization, support more timely referrals and discharge planning, reduce duplicative services, and connect people experiencing homelessness to appropriate housing, health, behavioral health, and supportive services. The CoC also uses aggregate and de-identified data, where appropriate, to identify system-level trends, inform Coordinated Entry and case conferencing, assess gaps in services, and guide resource allocation and program planning. Data sharing is conducted in accordance with HMIS policies, applicable privacy requirements, client releases/consent, and formal agreements governing the exchange and use of information.

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 MA-505-CoC partners with the MassHire Workforce Board/Career Centers throughout the CoC and SER Jobs to connect people experiencing homelessness with employment services, career counseling, job placement, skills training, and employer opportunities. CoC providers leverage MassHire and its network of education, vocational rehabilitation, and training partners to increase earned income, reduce barriers to employment, and strengthen housing stability and long-term independence.

An example of the success of such partnerships is demonstrated through one of the CoC's PSH program's that has a live-in aid who also works for MassHire further increasing and deepening the relationship and access to help more people toward self-sufficiency.

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

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

(limit 2,500 characters)

The CoC has developed an active, community-based approach to street outreach that emphasizes collaboration with law enforcement and first responders as partners in engagement. Across the CoC, outreach providers maintain working relationships with local Police Departments and public safety personnel to identify people experiencing unsheltered homelessness, coordinate responses, and facilitate warm handoffs to housing and supportive services.

In New Bedford, street outreach is closely connected to the Homeless Emergency Assistance Response Team (HEART), which brings together outreach, public safety, health and community partners to respond to individuals experiencing homelessness and encampments. HEART uses a compassionate-compliance approach focused on relationship-building, problem-solving and connections to shelter, housing, behavioral health, substance-use treatment and other services while addressing encampments. New Bedford Police also participate in the Community Crisis Intervention Team (CCIT), providing an established mechanism for law enforcement, behavioral health and community providers to coordinate responses to individuals experiencing behavioral health and other complex crises.

The CoC also maintains direct relationships with Police Departments throughout the Coc. In the northernmost areas of the CoC, outreach providers are embedded and participate in police ride-alongs, allowing outreach staff and officers to identify and engage individuals in the community together, increase officers' knowledge of available homeless services, and facilitate direct connections to outreach, Coordinated Entry and housing resources.

These partnerships extend beyond individual encounters. The CoC promotes co-response and diversion approaches that connect law enforcement and first responders with outreach workers, behavioral health professionals and other service providers and Coord Entry Team provides training to officers. This gives first responders practical alternatives for responding to homelessness and behavioral health concerns and helps reduce reliance on emergency departments, arrest and other crisis responses when appropriate.

Through these coordinated relationships, the CoC works to ensure that people experiencing unsheltered homelessness have positive, respectful interactions with first responders and are connected as quickly as possible to outreach, Coordinated Entry, housing and supportive services.

1C-8. Family or Support Network Reunification.

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

(limit 2,500 characters)

The projects within the CoC each understand the importance of establishing supports outside of court systems in order to achieve success. It is well known that many of the participants in projects enter into homelessness due to untreated issues including substance use and mental health that have created fractures in the family systems.

As programs work with participants to engage in treatment including substance use and mental health treatment, the case managers begins to work with the participants to reengage with their families and social supports. Outside programs such as the program in Taunton (part of the CoC) that provides funding through opiate lawsuit funds has assisted participants who were formerly using substances but have undergone treatment access to transportation assistance for participants to reestablish with family members.

Additionally working with faith based organizations, such as the St Vincent DePaul Society, the CoC has access to flexible funds to assist case managers working with clients to reestablish imperative relationships for success.

Case management in all CoC programs looks at the whole person to work through issues that resulted in homelessness. This includes their family and social networks. As a person begins working through treatment the case manager can assist in barriers that had torn down past relationships. Case management encourages clients to reach back out to positive social networks including their family, their church, faith community and the positive friendships they may have established prior to becoming homeless.

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

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

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

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

(limit 2,500 characters)

The MA-505 CoC works collaboratively with municipalities, police departments, fire and emergency medical services, behavioral health providers, and other first responders to support local efforts to address homelessness and improve community safety. The CoC does not interfere with or impede locally determined public safety, encampment, or community-response efforts. Instead, it works collaboratively with municipalities and first responders to ensure that housing and supportive-service options are available and that responses to homelessness are coordinated, respectful and connected to pathways out of homelessness.

The CoC assists first responders by providing access to street outreach, Coordinated Entry, emergency shelter, housing navigation, behavioral health and other supportive services. Outreach providers maintain direct relationships with local Police Departments and respond when first responders identify individuals who may need assistance. These relationships allow officers and other responders to make direct connections to outreach staff and appropriate services rather than relying solely on emergency departments, arrest or other crisis systems.

One such example of this is in New Bedford where the CoC works with the Homeless Emergency Assistance Response Team (HEART), which coordinates public safety, outreach, health and community partners in responding to individuals experiencing homelessness and encampments. HEART's compassionate-compliance approach emphasizes engagement, problem-solving and connections to appropriate shelter, housing and services. The CoC also participates in the Community Crisis Intervention Team (CCIT), strengthening coordination among law enforcement, behavioral health and community providers when individuals experience complex behavioral health or other crises.

In other communities, outreach providers maintain direct relationships with police departments, including police ride-alongs that allow outreach workers and officers to jointly identify and engage people experiencing homelessness and connect them to available resources.

Through these partnerships, the CoC supports local priorities while ensuring first responders have practical service pathways and a knowledgeable CoC system to which they can refer or directly connect individuals experiencing homelessness.

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

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

(limit 2,500 characters)

The MA-505 CoC works w/municipalities, law enforcement, public health, outreach providers, and first responders to address tents and encampments on public property while connecting people to shelter, housing, treatment, and supportive services. Local authority over public property, health, sanitation, and safety facilitates timely action when an encampment presents legitimate public health or safety concerns. The CoC recognizes, however, that limited shelter/housing capacity, individual refusal of placements, and the time needed to build trust can delay immediate transitions.

A key strength is coordinated, multidisciplinary engagement before and during encampment resolution. In New Bedford, the Homeless Emergency Assistance Response Team (HEART) brings outreach, public safety, health, and community partners together to engage people living in encampments. HEART uses a compassionate-compliance approach focused on relationship-building, problem-solving and connections to shelter, housing, behavioral health, and substance-use services. The CoC also coordinates with police departments and the Community Crisis Intervention Team (CCIT) when behavioral health or other complex needs are present. In the northern CoC geography, outreach staff participate in police ride-alongs, strengthening relationships and enabling real-time engagement.

The CoC leverages these practices through an encampment-response protocol emphasizing early notification, coordinated outreach, service assessment, and rapid placement. When an encampment is ID'd, the CoC coordinates with the municipality and public safety partners; conduct outreach before planned closure; assess individuals through Coordinated Entry; identify available shelter, housing, treatment, and supportive services; and provide warm handoffs. HMIS and Coordinated Entry will identify openings and match individuals to resources as quickly as possible.

Where restrictive policies, limited capacity, or short closure timelines prevent immediate placement, the CoC mitigates their effects through advance outreach, case conferencing, continued engagement, and rapid deployment of available resources. Closure does not end engagement: outreach teams continue working with individuals who cannot immediately accept or access placement. This approach enables municipalities to meet public-property and safety responsibilities while maximizing safe exits from encampments and pathways to appropriate services and PH.

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)

Tents and encampments represent a relatively small portion of unsheltered homelessness within the MA-505 CoC. Unlike larger encampments seen in some communities, the MA-505 CoC's encampments generally consist of no more than 2–3 tents and approximately 5–10 people. More commonly, the CoC encounters individuals who are unsheltered and living alone in vehicles, outside, or in other locations not meant for habitation.

The CoC maintains a centralized, continuously updated inventory of known encampments and unsheltered individuals through collaboration between its Coordinated Entry and street outreach teams. The CoC works to ensure that every person identified through outreach or other community partners is added to a comprehensive, CoC-wide by-name list. This allows the CoC to understand the scope and location of unsheltered homelessness, identify changes in circumstances, coordinate outreach and prioritize connections to appropriate housing and services.

Outreach teams maintain regular contact with people on the by-name list and coordinate with municipalities, police departments, first responders, behavioral health providers and other partners throughout the CoC. An example of this is coordination through the Homeless Emergency Assistance Response Team (HEART), including its compassionate-compliance approach to encampments. The northern part of the CoC has created the "POP" (Problem Oriented Policing) Team consisting of the PD, city social worker and ride-along clinician going to encampments to direct unsheltered homeless to treatment and shelter/housing.

Because encampments and unsheltered locations can change quickly, the CoC continually updates its inventory and by-name list. This system allows the CoC to identify emerging needs, avoid duplication of outreach, coordinate responses, and pursue appropriate shelter, housing and supportive services for each person. The CoC's goal is not simply to identify encampments, but to maintain a current understanding of every person experiencing unsheltered homelessness and move them toward treatment, self-sufficiency and housing.

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)

MA-505 recognizes that public drug use requires a coordinated public-health, housing and public-safety response—not enforcement alone. State policy provides: the Good Samaritan law protects people who seek medical assistance for an overdose, while state law protects good-faith provision of specified harm-reduction services. Massachusetts also supports syringe-service programs, naloxone distribution and linkage to treatment. Locally, New Bedford has LEAD, police/behavioral-health co-response, the Community Crisis Intervention Team (CCIT), Post-Overdose Outreach, the Opioid Task Force/Harm Reduction Subcommittee, and HEART. These partnerships support engagement, safety, Narcan/harm-reduction distribution, and connections to treatment, recovery and housing.

The CoC recognizes that criminal laws and municipal public-order requirements can create barriers when people experiencing homelessness lack safe alternatives, particularly where service capacity varies among municipalities. MA-505 will address these challenges by strengthening alternatives that reduce repeated public use, emergency responses and criminal-justice contacts while maintaining safety.

MA-505 will: (1) strengthen referral pathways among law enforcement, HEART/street outreach, LEAD, CCIT, behavioral-health providers, treatment/recovery services and Coordinated Entry; (2) train outreach and public-safety partners on Good Samaritan protections, harm reduction, de-escalation and available resources; (3) ensure outreach teams carry Narcan and harm-reduction materials and make warm handoffs to treatment/housing; (4) use case conferencing and HMIS/Coordinated Entry, consistent with consent and privacy requirements, to identify people with repeated public-use, overdose or homelessness contacts and develop individualized pathways; and (5) strengthen cross-municipal coordination so access to diversion, treatment, shelter and housing does not depend on where a person is encountered.

This approach leverages existing diversion and harm-reduction infrastructure while mitigating restrictive public-order impacts through rapid outreach, service connection, housing placement and coordinated follow-up.

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)

MA-505 continues to experience significant substance-use and overdose impacts, particularly among people experiencing homelessness and those with behavioral-health needs. At the same time, overdose mortality is declining statewide. Massachusetts recorded 978 confirmed and estimated opioid-related overdose deaths in 2025, a nearly 60% decline from the 2022 peak. Bristol County's opioid-related overdose death rate also declined substantially, from 52.8 per 100,000 in 2023 to 32.5 in 2024. However, Bristol County remained among Massachusetts' higher-rate counties, demonstrating that the crisis has not ended.

Current DPH data through December 2025 show that substance-related emergency events, including opioid-related EMS incidents and hospitalizations, remain significant. These data capture the continuing need for rapid intervention even as fatal overdoses decline. DPH also cautions that opioid-related EMS incidents include a range of events and are not synonymous with clinical overdoses.

Within the CoC geography, New Bedford remains a significant concentration of substance-use impacts. Massachusetts data identified New Bedford among the communities with high opioid-related overdose mortality rates, while the broader Bristol County geography includes both urban and suburban/rural communities with differing access to treatment, transportation and harm-reduction resources.

Public drug use is most visible in areas where homelessness, untreated behavioral-health needs, inadequate housing and substance-use disorders intersect. The CoC recognizes that publicly visible use, discarded drug paraphernalia, overdoses and related emergency/police contacts can affect residents, businesses and people experiencing homelessness and therefore require a coordinated public-safety response.

MA-505 is addressing these conditions through coordinated street outreach, HEART, LEAD/diversion, police-behavioral-health co-response, post-overdose outreach, treatment referrals and Coordinated Entry. The CoC will continue using HMIS, outreach and public-safety partner information to identify recurring contacts and connect individuals rapidly to treatment, recovery, shelter and permanent housing. This approach recognizes the current decline in mortality while addressing the continuing public-use and public-safety impacts of illicit drug use across the CoC.

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)

The MA-505 CoC works closely with law enforcement, behavioral health providers, first responders and courts to ensure that individuals experiencing homelessness who present a danger to themselves or others can be connected to appropriate crisis intervention and treatment. state law (MGL) provides important tools, including Section 12 for emergency psychiatric evaluation and Section 35 for involuntary substance-use treatment when statutory criteria are met.

A key CoC practice is the Community Crisis Intervention Team (CCIT), which strengthens coordination among law enforcement, behavioral health professionals and community providers when individuals experience acute or recurring behavioral health crises. In New Bedford, the CoC also works through the HEART Team, integrating outreach, public safety, health and behavioral health partners to engage individuals in crisis, including those homeless in encampments. Police Departments throughout the CoC maintain relationships with outreach providers, including Taunton police ride-alongs, creating opportunities for real-time assessment, engagement and referral.

The principal limitation is that involuntary interventions have defined legal thresholds and are intended for circumstances involving serious or imminent risk; homelessness, substance use or behavioral health needs alone do not establish grounds for involuntary commitment. Section 35, for example, requires a substance-use disorder and a likelihood of serious harm, with less restrictive alternatives considered.

The CoC will leverage these authorities by strengthening protocols among outreach, CCIT, HEART, law enforcement and behavioral health providers for identifying risk, making timely referrals and coordinating appropriate crisis responses. The CoC will provide training and technical assistance so outreach and first responders understand available intervention pathways and their respective roles. Following crisis intervention or discharge, outreach providers will pursue warm handoffs to shelter, housing, treatment and ongoing behavioral health services through Coordinated Entry and community partners. This approach balances public safety and individual rights while ensuring that involuntary intervention, when legally appropriate, is paired with continued engagement and a pathway to stable housing and services.

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)

MA-505 benefits from Massachusetts laws and practices that support timely sharing of sex-offender registration and location information while maintaining privacy protections. MA law requires the Sex Offender Registry Board (SORB) to transmit registration and address information to appropriate law-enforcement agencies, provides public access to Level 2 and Level 3 information, and requires homeless shelters receiving state funding to cooperate with SORB and local police when needed to verify an offender's registration or whereabouts. MA also requires registered individuals to report changes in residence and secondary addresses, providing an established framework for location-information sharing.

The principal challenge for MA-505 is not a lack of information, but fragmented systems, confidentiality requirements, and housing restrictions that may impede timely housing placement. SORNA itself does not restrict where a registered individual may live; however, state or local residency restrictions may limit available housing and unintentionally increase housing instability or homelessness.

The CoC will leverage existing policies by strengthening coordination among its HMIS Lead, homeless service providers, local law enforcement, SORB, probation/parole, and other appropriate public agencies. The CoC will establish clear procedures for providers to obtain and verify SORNA-related information through appropriate governmental authorities rather than informal or duplicative databases. Where legally permissible, providers will incorporate verified location and eligibility information into housing-placement and case-conferencing processes, limiting access to authorized personnel and protecting victims and other confidential information.

The CoC will identify housing barriers created by residency restrictions or other local practices and work with law enforcement, housing authorities, landlords, and municipal partners to identify lawful housing options and prevent unnecessary displacement. Where restrictions cannot be modified, the CoC will use housing navigation, landlord engagement, coordinated case conferencing, and cross-jurisdictional referrals to identify compliant alternatives. This approach supports SORNA's public-safety objectives while minimizing avoidable barriers to permanent housing and maintaining accurate, secure, and appropriately limited information sharing.

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 MA-505 CoC uses a coordinated, multi-agency outreach strategy to reach individuals and families experiencing homelessness throughout the CoC, including those living in shelters, vehicles, encampments, places not meant for habitation, and other less visible locations.

CoC-funded outreach providers maintain a regular presence throughout the CoC and working with shelters, food programs, hospitals, behavioral health providers, municipalities, police departments and other first responders to identifying and engaging people experiencing homelessness. Outreach staff conduct street-based engagement, respond to referrals, participate in community activities, and conduct targeted outreach to known locations where people experiencing homelessness congregate.

The CoCs strategy is strengthened through partnerships with public safety and behavioral health systems. In the northern area of the CoC outreach teams are embedded with the Problem Oriented Policing (POP) Team. In New Bedford, outreach is integrated with the Homeless Emergency Assistance Response Team (HEART), including its compassionate-compliance approach to encampments. Outreach providers also work with the Community Crisis Intervention Team (CCIT) and participate in police ride-alongs in Taunton and other communities. Such partnerships help identify individuals who may otherwise remain disconnected and create opportunities for warm handoffs to services.

The CoC uses Coordinated Entry as the central pathway connecting people identified through outreach to appropriate housing and services. Outreach staff assist with assessment, documentation, referrals and housing navigation while maintaining engagement with those not immediately eligible for or ready to accept available interventions.

The CoC prioritizes populations that can be difficult to engage, including people experiencing chronic or unsheltered homelessness, behavioral health or substance-use needs, families, veterans, youth and those disconnected from mainstream services. Through ongoing coordination, the CoC identifies geographic and population gaps and adjusts outreach to ensure individuals and families throughout the CoC have meaningful opportunities to enter the homeless response system and connect to housing.

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

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

		Written Agreement
1.	**Child Care (including Child Care and Development Fund)**	Yes
2.	**Early Childhood Providers**	Yes
3.	**Early Head Start**	Yes
4.	**Home Visiting Program (including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)**	Yes

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

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

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)	No
6.	Other Post-Secondary Education Provider(s)	Yes

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

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

(limit 2,500 characters)

The CoC (through its Collaborative Applicant and program grantee-- the City of New Bedford Office of Housing & Community Development (OHCD), requires all CoC and ESG-funded projects serving families, children, or youth experiencing homelessness to maintain written policies and procedures ensuring they are informed of their rights and eligibility for educational services under the McKinney-Vento Act and other applicable laws.

These policies require projects to: (1) inform families and youth of their educational rights and available services; (2) designate staff responsible for ensuring children are enrolled in school and connected to appropriate educational and community resources; (3) connect eligible children to the local McKinney-Vento liaison and services, including early childhood programs such as Head Start and Part C of the Individuals with Disabilities Education Act; and (4) ensure program policies do not restrict or interfere with rights provided under the education subtitle of the McKinney-Vento Act.

Projects also consider the educational needs of children when placing families in emergency shelter or transitional housing and, to the maximum extent practicable, place families with children as close as possible to their school of origin to minimize educational disruption.

The OHCD incorporates these requirements into CoC and ESG subrecipient agreements and monitors compliance through project monitoring, requiring documentation that policies are implemented in practice. Project applicants must be able to demonstrate compliance and identify corrective actions when deficiencies are found. Through these requirements, the CoC ensures that access to housing and homeless services does not create barriers to school enrollment, school stability, transportation, or other educational services for children and youth experiencing homelessness.

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)

Through the family shelter system as well as public schools, current CoC projects, and state funded projects for unaccompanied youth, the interaction with the child welfare system is ongoing.

The unaccompanied youth program works directly with the state foster care system to identify youth aging out of care to provide outreach and resources for housing and education. This is an attempt to prevent these youth from entering into homelessness upon discharge from the system.

In cases where an unaccompanied youth is identified they are prioritized for shelter placement and case management works to reestablish them with the child welfare system if they are potentially eligible for services for youth aging out of the system.

Additionally, one of the faith-based providers of CoC services has recently submitted a grant to work directly with the state child welfare services to identify youth while in care who may need additional assistance with mental health issues and skills necessary to be successful upon discharge from the system. This grant allows for an increase in an already established youth mentor program as well as establish groups for youth and families working through issues including behavioral health, grief, and life skills.

The goal of the CoC is to establish youth who may need assistance upon transitioning from care and establish a path toward success including access to college and potential free community college education, access to mental health treatment, and prioritization for housing.

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

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

(limit 2,500 characters)

The MA-505 CoC maintains strong coordination with Catholic Charities of the Fall River Diocese (CCFR) which has state funding to ensure that youth experiencing or at risk of homelessness are identified quickly and connected to appropriate housing and supportive services. The CoC's emergency shelter system prioritizes placement for runaway and homeless youth when appropriate, providing an immediate point of safety while youth are connected to longer-term housing and services through Coordinated Entry and community-based providers.

The CCFR, a key homeless youth service provider, is an active partner in the CoC whose CEO serves on the CoC Executive Board, providing direct organizational leadership and ensuring that youth homelessness priorities are incorporated into CoC planning, policy, and resource allocation. CCFR and other youth-serving partners coordinate with the CoC through case conferencing, Coordinated Entry, referrals, and shared planning to facilitate access to shelter, housing, behavioral health, education, employment, and other supportive services.

The CoC works collaboratively with Street Outreach and providers serving youth throughout the CoC establishing referral pathways and minimizing barriers to service access. Youth identified through outreach or crisis programs are connected to Coordinated Entry and appropriate housing interventions, while youth with immediate safety needs can access emergency shelter. This cross-system coordination helps ensure that youth do not have to navigate multiple systems independently and supports a seamless transition from crisis response to stable housing and self-sufficiency.

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)

The MA-505 CoC has family-focused TH/RRH resources integrated with Coordinated Entry to connect families with children to shelter, temporary housing, rapid rehousing, and permanent housing. Providers leverage mainstream resources, including the State's' HomeBASE program, to resolve housing crises, reduce shelter stays, and address barriers to housing stability. The CoC's FY2026 portfolio further expands family TH capacity and strengthens this coordinated pathway to permanent housing.

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

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

(limit 2,500 characters)

The Family Preservation Program (FPP), a 20-unit Permanent Supportive Housing program serving families in the MA-505 CoC, makes increasing household income a core strategy for housing stability. Case managers work with each household to identify employment barriers, establish individualized income and employment goals, and connect families to workforce, education, and career pathways that can increase their ability to pay rent and sustain housing.

FPP has established partnerships with MassHire for job readiness, resume development, and placement; MassAbility for vocational rehabilitation, accommodations, and disability-related employment barriers; and Bristol Community College for certificates and degrees linked to in-demand occupations and longer-term wage growth. For participants interested in recovery-related careers, FPP partners with faith-based Calvary Cares to support recovery coach training, creating a pathway to meaningful employment while reinforcing participants' recovery goals.

FPP goes beyond referral-based services. Regular on-site workshops bring partner agencies directly to residents to explain available programs, eligibility, and career pathways. Case managers then provide individualized follow-up, track progress toward employment and income goals, address barriers, and reinforce connections through each household's individualized service plan. This integrated approach helps families move from connection to services to actual participation and employment.

These partnerships and practices will be carried forward into the agency's proposed Transitional Housing program and new family PSH project, creating a consistent income-growth strategy across the CoC's expanding family housing portfolio. Participants will have access to employment, education, credentialing, disability-employment, and recovery-career pathways regardless of housing intervention.

By integrating housing stabilization with workforce development and education, the CoC strengthens families' capacity to increase earned income, improve rent affordability, reduce reliance on housing assistance over time, and achieve sustained housing stability.

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

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

(limit 2,500 characters)

The Family Preservation Program (FPP) systematically leverages mainstream family service systems to maximize resources available to each household and strengthen housing and income stability. At intake and throughout participation, case managers screen every family for eligibility for TANF and other mainstream benefits and provide hands-on assistance with applications, recertification, and compliance. This proactive approach helps families maintain eligible benefits while pursuing increased earned income.

FPP connects eligible families to SNAP, MassHealth, DTA programs, WIC, and the State's Department of Early Education and Care (EEC) childcare subsidies. Childcare assistance removes a significant barrier to employment, education, and vocational training. Families are also connected to Head Start and Early Head Start when eligible, reducing household expenses while supporting children's development. The program also coordinates with HomeBASE to leverage available housing stabilization and relocation resources, helping families resolve housing crises and access alternatives when appropriate.

FPP's approach is designed to maximize, not duplicate, available resources. Case managers coordinate with mainstream providers and help families access benefits for which they are eligible, allowing CoC resources to remain focused on housing stabilization, intensive case management, supportive services, and workforce development. As earned income changes, staff help families navigate benefit transitions to support greater economic independence without jeopardizing housing stability.

These strategies will extend to the agency's proposed Transitional Housing and new family PSH projects, creating a consistent approach across the expanded portfolio. By combining CoC resources with mainstream benefits and HomeBASE, FPP increases resources available to families, reduces household expenses, removes barriers to employment, and strengthens long-term housing stability.

1C-13c. Collaboration Related to Families with Children—Combining Housing Assistance with Parental Support.

Describe how the project(s) identified in 1C-13 combines housing assistance with childcare, parenting support, pregnancy-related and child healthcare, and education.

(limit 2,500 characters)

The Family Preservation Program (FPP) integrates housing assistance with coordinated services that address the health, education, development, and well-being of both parents and children. The program recognizes that lasting housing stability requires addressing the family circumstances that can undermine a parent's ability to work, care for children, and maintain housing.

Case managers ensure children are enrolled in school and advocate with families on IEP/504 plans, attendance, and other educational needs. For pregnant participants, staff assist with prenatal and OB-GYN care and connect families to WIC. FPP also coordinates with childcare and early-education providers, including YMCA, PACE, and Northstar Learning, helping parents complete enrollment, address transportation barriers, and secure reliable childcare so they can pursue employment, education, and training.

FPP connects families to HomeBASE when eligible, leveraging housing stabilization resources to address housing-related barriers and preserve family stability while CoC resources remain focused on supportive housing services. Staff also connect eligible youth to MassHire, YouthWorks, and YouthBuild, providing pathways to employment, education, and workforce development.

Parenting and family functioning are addressed through collaboration with Child and Family Services for parenting education and emotional supports for parents and children. When DCF is involved, FPP maintains active communication and coordinates service plans and goals to support family preservation and reunification when appropriate.

These partnerships will extend to the agency's proposed family Transitional Housing and PSH projects, creating a consistent service model across the expanded portfolio. Through integrated housing assistance, childcare, education, healthcare, parenting support, and mainstream resources, FPP reduces barriers that threaten housing stability and strengthens families' capacity to achieve safe, healthy, and sustained housing.

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

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

(limit 500 characters)

The CoC has multiple partnerships with veteran focused organizations including VSOs in the CoC and several veteran housing providers--Veteran Transition House and Veterans Inc.. One housing provider is currently entering into an agreement with a veteran service provider to share a permanent housing project for veterans and older adults. The CoC meets with the Providence VA in monthly by name list meetings to identify and house veterans in the CoC

** **

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

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

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

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

(limit 500 characters)

The MA-505 CoC partners with victim service providers, including domestic violence and sexual assault organizations (like The Women's Center) to ensure individuals and families fleeing violence can access safe shelter, housing, and trauma-informed services. Through Coordinated Entry and established referral pathways, the CoC coordinates confidential, survivor-centered access to emergency shelter, Rapid Rehousing, and PSH while prioritizing safety, housing stability, and client choice.

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)

CoC members CCBC and Steppingstone have CSP-JI programs. These programs work with those currently incarcerated to establish services necessary to transition in a positive manner back into the community and offer ongoing services to stabilize. Additionally, CCBC engages with the local drug court to obtain and accept referrals for substance misuse treatment in the Co-Occurring program for both mental health and substance use.

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)

Community Counseling of Bristol County, Inc (CCBC) has active MOU's with the largest hospital Emergency Departments in the CoC. This allows the agency to engage with homeless individuals frequenting the ED and begin to engage them in the Community Support Program to help them gain access to treatment, housing and basic needs to reduce overall medical costs.

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)

The MA-505 CoC leverages partnerships with COAs, senior housing, healthcare, and community-based providers to connect aging individuals experiencing homelessness to permanent housing and needed supportive care. Through Coordinated Entry, case conferencing, and targeted referrals, the CoC identifies medical, functional, and housing needs early and coordinates services that promote housing stability, reduce returns to homelessness, and support aging in place.

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

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

(limit 500 characters)

While the CoC's current PSH projects all prioritize individs experiencing chronic homelessness, the CoC is reallocating the majority of its portfolio to improve outcomes, etc. In so doing, all new projects will prioritize chronic homelessness. One such PSH is CCBC's Homes With Heart PSH using Coordinated Entry and data-driven prioritization to identify people with the highest housing barriers and longest histories of homelessness, connecting them to permanent housing and tailored supports.

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 MA-505 CoC has an MOU with Community Counseling of Bristol County, Inc. (CCBC), a Certified Community Behavioral Health Clinic (CCBHC) and Community Behavioral Health Center (CBHC). As part of the CoC's strategic restructuring, all existing PSH projects were reallocated; this successful service model will continue under a revised Homes With Heart II project. Homes With Heart II will prioritize chronically homeless individuals and families, providing integrated behavioral healthcare to promote housing stability, recovery, and self-sufficiency.

On-Site Behavioral Healthcare: Homes With Heart II will maintain dedicated clinical capacity at residential sites, including a licensed clinical social worker and mental health counselor. Residents will have access to individual and group counseling using evidence-based approaches, including CBT, and DBT. Clinical staff will coordinate with CCBC's CCBHC/CBHC outpatient services, PACT, and other providers to ensure continuity and appropriate care.

Crisis Response and Medication Support: On-site clinicians will provide proactive engagement, assessment, de-escalation, and crisis intervention. CCBC's Mobile Crisis Intervention team will be available for urgent behavioral health needs, supporting rapid response while maintaining residents safely in housing whenever appropriate. Residents will have access to psychiatric evaluation, prescribing, medication management, and nursing support, including on-site medication monitoring when indicated.

Assessment and Higher-Level Care: Homes With Heart II will use ongoing clinical assessment, case conferencing, and coordination with behavioral health providers to identify changes in functioning, acuity, safety, substance use, or ability to maintain tenancy indicating a need for higher-level care. When indicated, staff will coordinate referrals to intensive community-based treatment, PACT, co-occurring-disorder treatment, residential treatment, or other appropriate services.

This approach preserves and strengthens the CoC's behavioral health capacity while aligning the redesigned PSH portfolio with current needs and HUD expectations.

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 MA-505 CoC maintains a formal written policy requiring that Permanent Supportive Housing (PSH) participants who need a higher level of care be assessed and, when appropriate, transitioned to a more suitable setting. This policy is actively implemented across CoC-funded PSH projects, including the existing Homes With Heart (HWH) PSH Project, operated by Community Counseling of Bristol County, Inc. as will be the case with its proposed HWH II PSH project.

The CoC's assessment approach is collaborative and person-centered, as demonstrated by the current HWH operation.

Ongoing Case Management: Case managers conduct regular assessments of participants' behavioral health, physical health, and ability to perform activities of daily living, connecting them to resources as concerns arise.

Interdisciplinary Review: When a participant's tenancy is at risk due to significant health or behavioral concerns, staff convene a case conference with HWH staff, the participant's behavioral health and medical providers, and CoC Coordinated Entry staff to jointly review needs.

Levels of Care Assessment: The interdisciplinary team evaluates whether specialized care—such as co-occurring residential treatment, medical or behavioral health respite, or skilled nursing—is warranted. Participants remain central to this process, with choices offered that balance safety and tenancy rights.

Ongoing Care Coordination: When a higher level of care is indicated, HWH coordinate (and will continue to coordinated) directly with behavioral health, medical, and social service systems to facilitate a smooth transition while preserving housing stability and preventing returns to homelessness.
This structured, participant-driven process allows the CoC to identify emerging needs early while connecting individuals to appropriate care—maximizing housing retention and reducing returns to homelessness system-wide.

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)

The MA-505 CoC promotes move-on strategies in every PSH project, recognizing that participants who no longer require intensive case management should transition to long-term affordable housing—freeing PSH capacity for households with the highest needs, consistent with HUD's priority of maximizing PSH for chronically homeless persons. This strategy is actively implemented, including at CCBC's Homes With Heart II (HWH II) PSH proposed project. As has been the case with the existing HWH PSH project, the HWH II will meet with all participants to assess and determine appropriate move-on options. Residents who are employed and have developed self-sufficiency resources are identified as ready to transition into stable, independent housing.

CoC Move-On Assessment Policy:

Screening: The CoC is developing a standardized move-on assessment tool in collaboration with local PHAs to systematically evaluate readiness.

Indicators: Assessment focuses on tenancy stability, including lease compliance, consistent ability to pay rent and utilities, readiness for independent living, and connection to mainstream community resources.

Housing Authority Partnerships: The CoC maintains strong partnerships with local Housing Authorities. HWH II staff currently use a Housing Navigator and a centralized portal to track participants' status on waitlists, expediting transitions.

Transition of Care & Follow-Up: Participants who move on retain access to mainstream supportive services, including the Community Support Program for Homeless Individuals (CSP-HI) and Health-Related Social Needs (HRSN) funding for transitional household goods, ensuring continuity of care.

As participants move on, their PSH units are immediately filled with prioritized households from the Coordinated Entry list to ensure a housing pipeline that is nimble, responsive and efficient.

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

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

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

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

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

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

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

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

	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website–which included: 1. the CoC Application, and 2. Project Priority Listings.	09/27/2026

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

	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/27/2026

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

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

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

1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	No

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

	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	07/24/2026

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

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

(limit 2,500 characters)

1.The MA-505 CoC used the 2026 CoC NOFO competition as an opportunity to conduct a comprehensive, system-level review of its entire project portfolio rather than simply renew existing projects. The CoC evaluated projects based on performance, utilization and outcomes, cost-effectiveness, alignment with current community needs, housing and service outcomes, project design, and the extent to which projects advanced HUD and CoC priorities. Projects that were underperforming, duplicative, less needed, or no longer the best use of limited CoC resources were identified as candidates for reallocation.

2.The CoC identified multiple existing projects for significant amendment, replacement, or elimination through this process. Rather than making isolated reallocations, the CoC intentionally used the competition to reshape its portfolio and invest resources in a stronger mix of projects designed to address identified gaps and produce improved outcomes. This included reallocating resources from projects that were less aligned with current system needs toward new, higher-performing project models.

3.As a result, the local competition produced a substantial realignment of the CoC portfolio. The resulting request includes new Transitional Housing (TH) and Supportive Services Only (SSO) projects, while reducing the overall proportion of Permanent Supportive Housing (PSH). This was an intentional strategic decision based on the CoC's assessment of current needs, existing system capacity, project performance, and opportunities to improve the overall homeless response system. The change does not reflect a diminished commitment to PSH; rather, it reflects a determination that a more balanced portfolio, including TH and SSO capacity, is necessary to address unmet needs and strengthen pathways to housing.

Accordingly, the CoC did identify low-performing or less-needed projects, did reallocate resources through its local competition, and used the 2026 NOFO as a deliberate opportunity to reboot portions of the portfolio. The resulting portfolio is intended to be more responsive to community needs, more performance-driven, and better aligned with HUD's expectations for effective, outcome-focused CoC investments.

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

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

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

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

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

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

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

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

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

2A-3.	PIT Count–Methodology Change.	

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

(limit 2,500 characters)

1.The MA-505 CoC unsheltered PIT count implementation and methodology remained unchanged for the 2026 count, aside from the elimination of gender reporting. No changes were made to its unsheltered (nor sheltered) PIT Count implementation, methodology, or data-quality procedures between the 2025 and 2026 PIT Counts. The CoC continued to use the same established approach to identifying and counting persons experiencing unsheltered homelessness, including the same geographic coverage, outreach and enumeration practices, and data collection and validation procedures.

2.As a result, there were no changes in methodology or data quality that affected the comparability of the 2026 results with the 2025 results. Any change in the number of persons identified as unsheltered between the two years therefore reflects the conditions observed during the respective PIT Counts rather than a change in the CoC's counting methodology.

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

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

(limit 2,500 characters)

The MA-505 CoC addresses encampments through an ongoing, coordinated system of Street Outreach, Coordinated Entry, and housing-focused case management rather than through isolated or temporary encampment interventions. Street Outreach teams maintain regular contact with individuals residing in encampments and other locations not meant for habitation, building trust and identifying opportunities to connect individuals to treatment shelter, housing and supportive services. Outreach staff work with the CoC’s Coordinated Entry team to ensure that people experiencing unsheltered homelessness are assessed, prioritized, and connected to available housing opportunities as quickly as possible.

The CoC also uses cross-agency case conferencing and coordinated problem-solving to address individual barriers to housing, including behavioral health, substance use, medical, documentation, benefits, transportation, and other needs. When shelter or housing becomes available, Outreach and Coordinated Entry staff work together to quickly facilitate referrals and transitions, helping reduce the length of time individuals remain unsheltered or in encampments.

This approach allows the CoC to maintain continuous engagement with people living in encampments, identify changing needs, and pursue housing and appropriate interventions. The CoC’s strategy is therefore focused on reducing the number and duration of people experiencing unsheltered homelessness through sustained engagement, coordinated access to treatment, housing and services, and rapid connection to resources aimed at maximizing stability and independence.

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

1. Enter the estimated number of encampments in the beginning of your evaluation period.	22
2. Enter the reduction in the number of encampments during your evaluation period.	16

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

1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	110
2. Enter the reduction in the number of people in encampments during your evaluation period.	81

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)

The MA-505 CoC has made measurable progress in reducing the number of people residing in encampments and the number of encampments across the CoC's geography. While the CoC does not maintain a single comprehensive ongoing count of encampments, information from Street Outreach teams, Coordinated Entry, community partners, and the annual PIT Count indicates an overall reduction over the past year. The CoC recognizes, however, that encampments remain a significant concern and is committed to further reducing both the number of encampments and the number of people residing in them.

The CoC's strategy is built on sustained, coordinated engagement rather than short-term displacement. Street Outreach teams maintain regular contact with individuals in encampments and other locations not meant for habitation, while Coordinated Entry Team (CET) ensures that individuals are assessed, prioritized, and connected to available shelter, transitional housing, permanent housing, and supportive services. Outreach staff and the CET use ongoing case conferencing and cross-agency coordination to identify barriers, resolve documentation and service-access issues, and accelerate connections to appropriate housing and treatment resources.

Going forward, the CoC will strengthen this approach by improving the identification and tracking of encampments, maintaining consistent outreach coverage, strengthening information-sharing among outreach, housing, behavioral health, public safety, and other community partners, and prioritizing individuals with histories of unsheltered homelessness for available housing and services. The CoC will use PIT, HMIS, Coordinated Entry, and outreach information to monitor progress and identify gaps requiring additional intervention.

This strategy is intended to achieve two complementary outcomes: fewer people experiencing homelessness in encampments and shorter periods of time spent living unsheltered. The CoC will continue building on the progress already achieved while pursuing additional partnerships and resources to move people from encampments to stability through housing and services.

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 MA-505 CoC's plan to reduce first-time homelessness is centered on prevention, diversion, and earlier intervention, supported by the CoC's direct role in coordinating the community's homelessness response system and connecting households to resources before a housing crisis becomes homelessness.

The CoC works closely with the City of New Bedford and its ESG-funded prevention activities, including identifying and connecting households at imminent risk to available stabilization assistance. The CoC also coordinates with partners administering HOME-ARP resources, including Tenant-Based Rental Assistance (TBRA), to connect eligible households to longer-term housing stabilization. These resources are integrated with State programs such as RAFT and HomeBASE and with mainstream rental assistance, benefits, behavioral health, employment, and other supports.

Critically, the CoC's Coordinated Entry system and provider network serve as the community's principal mechanism for identifying housing crises, conducting problem-solving and diversion, determining appropriate interventions, and connecting households to available resources. CoC staff and participating providers actively coordinate referrals across programs rather than treating prevention resources as separate systems. When a household cannot be stabilized or diverted, the CET facilitates a rapid connection to shelter, treatment, transitional housing, rapid rehousing, permanent housing, and/or supportive services.

The CoC is strengthening this role by using HMIS, Coordinated Entry, PIT, and provider-level information to identify patterns in first-time homelessness, understand where households are entering the system, and identify gaps in prevention capacity. The CoC will use its governance, case conferencing, performance-monitoring, and cross-sector partnerships to continually align resources with emerging needs.

Through this coordinated approach, the CoC is working to prevent homelessness before it occurs, divert households whenever appropriate, and minimize the number of people who experience homelessness for the first time. The CoC will continue leveraging and better integrating ESG prevention, HOME-ARP/TBRA, RAFT, HomeBASE, and other public and private resources to expand the community's capacity to achieve these outcomes.

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 MA-505 CoC's strategy to reduce the length of time individuals and families remain homeless is to make the system faster, more coordinated, and more effective at moving people from homelessness to stable housing. The CoC is using its 2026 portfolio realignment as an opportunity to strengthen the mix of interventions available to people at different stages of homelessness and to prioritize projects capable of producing timely housing outcomes.

Coordinated Entry is the central mechanism for achieving this objective. The CoC will strengthen real-time identification, assessment, prioritization, referral, and case conferencing so that people do not remain in shelter, unsheltered locations, or transitional settings while waiting for a disconnected series of services. Complimenting this--Street Outreach will rapidly connect people experiencing unsheltered homelessness to shelter, transitional housing, treatment, supportive services, and housing.

With this 2026 CoC NOFO application, the MA-505 CoC is also expanding and diversifying its portfolio to improve pathways out of homelessness, including new Transitional Housing and Supportive Service Only projects, while introducing limited permanent housing resources for individuals and families requiring longer-term assistance. This more varied portfolio is intended to provide appropriate interventions without requiring every household to follow the same pathway to housing.

The CoC will actively address common delays—including documentation, benefits, behavioral health and substance-use needs, housing search, landlord engagement, transportation, and other barriers—through cross-provider case conferencing and housing navigation. The CoC will also maximize connections to available resources, including treatment, rental assistance and other housing stabilization programs.

Finally, the CoC will use HMIS, Coordinated Entry, PIT, and system-performance data to identify where delays occur, monitor length of time homeless, evaluate project performance, and target corrective action. By combining stronger system coordination, a more responsive project portfolio, active problem-solving, and performance accountability, the CoC will pursue measurable reductions in the time individuals and families remain homeless and ensure that homelessness is as brief as possible.

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

Based on HMIS data, what percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing?	52.00%

Describe how you calculated the data for this response.

(limit 2,500 characters)

Using HMIS data, an APR was run for all CoC funded programs. Leavers were reviewed and destinations were analyzed for that cohort (owner and rental unsubsidized unit destinations). The total number of individuals moving from PSH (there were no leavers from TH/RRH projects during the period) was compared with the number of those only going to unsubsidized housing was determined and the resulting ratio between those two numbers provided the percentage reported.

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

	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/28/2026

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

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

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

	Did your CoC submit at least two usable LSA data files to HUD in HDX 2.0 by January 16, 2026, 11:59 p.m. EST?	No

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

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

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

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

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	366	30	396	100.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	72	13	13	15.29%

4. Rapid Re-Housing (RRH) beds	1,639	0	0	0.00%
5. Permanent Supportive Housing (PSH) beds	364	0	277	76.10%
6. Other Permanent Housing (OPH) beds	69	0	28	40.58%

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. In 2026, the MA-505 CoC strengthened PIT implementation through expanded coordination with outreach and shelter providers, closer HMIS review, and reconciliation with available state and external data to improve completeness and reduce duplication.(The CoC easily accesses this data thereby negating duplicative reporting as it is not practical. Including this inventory would increase PSH coverage to approximately 99%. OPH coverage is similarly affected by VA-funded vouchers and other federally administered housing over which the CoC has no control or leveraging power.)

2. The CoC will pursue 85% coverage through a targeted provider-engagement and data-integration strategy. For TH, where virtually all inventory is funded outside the CoC Program, the CoC will establish a formal annual HIC/PIT participation request, designate a CoC liaison for non-CoC-funded providers, and incorporate provider-submitted inventory and utilization data into its validation process. For PSH, the CoC will commit to a formal data-sharing/integration arrangement with EOHLC to ensure the approximately 1,615 HomeBASE Stabilization beds are consistently captured in HIC reporting. Including this inventory would raise PSH coverage to approximately 99%. For OPH, the CoC will similarly engage VA and other federally administered housing partners to obtain annual inventory and utilization information and establish a documented process for incorporating that data.The CoC will track participation annually, identify providers and inventories not reporting, conduct direct follow-up before HIC submission, and elevate unresolved participation barriers through CoC leadership and state/federal partners. These steps will increase measurable coverage while avoiding duplicative HMIS reporting where authoritative data already exist in another system.

3A. Policy Initiatives

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

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

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

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

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

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

4A. Attachments Screen For All Application Questions

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

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

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

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

Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	ATTACHMENT 1C-1 L...	09/19/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	ATTACHMENT 1C-1f ...	09/20/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	ATTACHMENT 1C-3 L...	09/22/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	ATTACHMENT 1C-10 ...	09/24/2026
05. 1D-1. Local Competition Scoring Tool	Yes	ATTACHMENT 1D-1 L...	09/20/2026

06. 1D-2c. Local Competition Selection Results	Yes	ATTACHMENT 1D-2c ...	09/24/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	ATTACHMENT 2A-8b ...	09/20/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No	ATTACHMENT 3A-1. ...	09/24/2026
09. 3A-2a. Project List for Other Federal Statutes	No	ATTACHMENT 3A-2a ...	09/21/2026
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No	ATTACHMENT 3A-DP ...	09/21/2026
11. Other	No		

Attachment Details

Document Description: ATTACHMENT 1C-1 LIST OF TH.RRH.PSH PROJECTS AND TREATMENT PROVIDERS WITH ONSITE SUBSTANCE USE TREATMENT

Attachment Details

Document Description: ATTACHMENT 1C-1f LIST OF COC PROGRAM PROJECTS AND NUMBER OF UNITS THAT REQUIRE SUBSTANCE ABUSE TREATMENT

Attachment Details

Document Description: ATTACHMENT 1C-3 LANGUAGE FROM PROJECT SUPPORTIVE SERVICE AGREEMENTS

Attachment Details

Document Description: ATTACHMENT 1C-10 EVIDENCE OF COORDINATION AND NON-INTERFERENCE WITH LOCAL EFFORTS TO ADVANCE PUBLIC SAFETY

Attachment Details

Document Description: ATTACHMENT 1D-1 LOCAL COMPETITION SCORING TOOL.

Attachment Details

Document Description: ATTACHMENT 1D-2c LOCAL COMPETITION SELECTION RESULTS

Attachment Details

Document Description: ATTACHMENT 2A-8b FY 2026 HDX COMPETITION REPORT

Attachment Details

Document Description: ATTACHMENT 3A-1. HUD-2996 CERTIFICATION FOR OPPORTUNITY ZONE PREFERENCE POINTS

Attachment Details

Document Description: ATTACHMENT 3A-2a PROJECT LIST FOR OTHER FEDERAL STATUTES

Attachment Details

Document Description: ATTACHMENT 3A-DP COC POLICY TO ADVANCE RECOVERY

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/24/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/24/2026
1C. Coordination and Engagement	09/24/2026
1D. Project Review/Ranking	09/24/2026
2A. HMIS Implementation	09/24/2026
3A. Policy Initiatives	09/24/2026
4A. Attachments Screen	09/24/2026
Submission Summary	No Input Required

1C-1
ATTACHMENT

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

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

Transitional Housing (TH) & Transitional Support Services (TSS)	
	High Point Treatment Center – Transitional Support Services (TSS) (New Bedford): A 32-bed short-term residential/transitional program bridging medical detox/CSS to long-term recovery housing providing 24/7 on-site clinical supervision, relapse prevention, psychoeducational groups, and Medication-Assisted Treatment (MAT) coordination.
	Community Counseling of Bristol County (CCBC) – Transitional Housing with supportive case management: A site-based transitional supportive housing program accommodating homeless adults with substance use disorders for up to 24 months, with on-site case management and direct clinical addiction treatment.
	SEMCOA Unity House – Transitional Housing (TH) (New Bedford): Transitional housing with substance use treatment for single male residents for up to 24 months with onsite case management and direct clinical addiction treatment.
	Monarch House—Transitional Housing (TH) (New Bedford): Transitional housing with substance use treatment for single female residents for up to 24 months with onsite case management and direct clinical addiction treatment.
Permanent Supportive Housing (PSH)	
	Community Counseling of Bristol County (CCBC) – Homes with Heart (PSH) (Taunton/Attleboro): Provides long-term subsidized supportive housing for individuals with histories of chronic homelessness and substance use disorders, integrating on-site crisis intervention, psychiatric evaluation, and addiction therapy.
	Positive Action Against Chemical Addiction (PAACA) – (PSH) (New Bedford): Operates permanent supportive housing units combined with direct peer-led recovery coaching, 12-step facilitation, and on-site recovery support infrastructure.
	Steppingstone Welcome Home - (PSH) (New Bedford) Operates permanent supportive housing units combined with direct peer-led recovery coaching, 12-step facilitation, and on-site recovery support infrastructure.
	SEMCOA Family Preservation Program - (PSH) (New Bedford) Operates permanent supportive housing units specifically for families with minor children combined with direct peer-led recovery coaching, 12-step facilitation, and on-site recovery support infrastructure.
Rapid Rehousing (RRH) Providers	
	Positive Action Against Chemical Addiction (PAACA) – RRH Units (New Bedford): Operates rapid rehousing units combined with direct peer-led recovery coaching, 12-step facilitation, and on-site recovery support infrastructure.

1C-1f
ATTACHMENT

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

CoC Program Projects and Number of Units Requiring Program Participant Engagement in Substance Abuse Treatment Services as a Condition of Continued Participation in the Program			
Project Name	**Agency**	**Project Type**	**Number of Units Requiring Substance Abuse Treatment**
Existing CoC Projects			
Portico	Catholic Charities of the Fall River Diocese (CCFR)	PSH	0
Steadfast	CCFR	PSH	0
Family Preservation Program	SEMCOA	PSH	37
Step Up	PAACA, Inc.	PSH	0
Welcome Home	Steppingstone, Inc.	PSH	0
Homes with Heart	Community Counseling of Bristol County (CCBC)	PSH	0
Total Existing			**37**
Proposed CoC Projects			
Homes with Heart II	CCBC	NEW PSH	16
Family Preservation Program II	SEMCOA	NEW PSH	5
NB Permanent Housing Project	Steppingstone, Inc.	NEW PSH	7
Transitional Support Program	SEMCOA	NEW TH	12
Transition to HOME	CCBC	NEW TH	11
NB Transitional Housing Project	Steppingstone, Inc.	NEW TH	15
Recovery Works Transitional Housing Program	PAACA	NEW TH	18
TWC Bristol County Transitional Housing Program	SEMCOA	NEW TH	0
Total Proposed			**42**

NOTE: Although only one project within the existing CoC Portfolio required program participant engagement in substance abuse treatment, all existing projects are being reallocated to realign and improve outcomes. In so doing, every new housing project will require this as condition of continued program participation.

1C-3
ATTACHMENT

Language from Project
Supportive Service Agreements

The pages that follow provide two examples of Project Supportive Service Agreements compelling participant participation in supportive services:

1. **Existing Project: PAACA's Step Up PSH.**
   A copy of the PSH's "Step-Up Program Lease" and the accompanying Exhibit A (part of the sub-lease executed by the project participant).

2. **New Project: SEMCOA's (Family) Transitional Support Program TH.**
   A copy of the TH's Contract of Participation required of each project participant.

PAACA PSH Program
This lease DOES NOT include utilities

STEP-UP PROGRAM LEASE

BY THIS AGREEMENT on the date set forth below, the following parties have agreed to enter into this Step-Up Program Lease pursuant to the provisions herein: The parties to this Agreement are **Positive Action Against Chemical Addiction, Inc.**, 360 Coggeshall Street, New Bedford, Massachusetts 02746, hereinafter referred to as "**PAACA**" and **(PROGRAM PARTICIPANT)**, hereinafter referred to as "**TENANT."**

PAACA and TENANT agree that PAACA is providing this Unit (as set forth below) in exchange for TENANT's complete compliance with ***all*** program rules and Department of Housing and Urban Development ("HUD") Rules and Regulations governing the operation of PSH programs, including but limited to those contained herein and attached hereto as **EXHIBIT A**. Violation of any rule may result in immediate termination from the program and if necessary the filing of an eviction proceeding against the Tenant under HUD rules and regulations.

1. PREMISES: **PAACA** agrees to lease to **TENANT** the premises situated at _____, located in the City of **New Bedford**, Bristol County, Massachusetts, and described as follows: **Apartment # Bedrooms _____** (hereinafter referred to as "PREMISES") together with all appurtenances.

2. RENT: The rent for the Premises is $ _____ per month, which shall be payable on the first day of each calendar month during the term of this lease agreement. If PAACA does not receive a rent payment within five (5) days of the due date, PAACA will provide notice (oral or written) of the delinquency. The TENANT will make the delinquent payment within five (5) days of receiving said notice.

> 2.1 TENANT will pay the following portions of the above rent to PAACA:
> Ten percent (10%) of TENANT'S monthly gross income or thirty percent (30%) of monthly adjusted income, whichever is greater. PAACA will calculate the rent semi-annually as outlined in HUD Form 213.
>
> PAACA will pay the difference between the amount the TENANT pays and the amount set forth above.

3. TERM: This Agreement is for one (1) year commencing on the date set forth below and expiring one year after that, upon which time the parties will enter into a new lease agreement for a period mutually agreed to by the parties (and in conformity with all applicable HUD program guidelines and requirements). PAACA may terminate this Agreement at the end of the initial term. PAACA may also terminate this Agreement at the end of any month during the term by giving at least thirty (30) days written notice in advance to TENANT if (1) PAACA has reasonable cause to terminate the lease based upon the lack of compliance with the TENANT'S program obligations, duties and responsibilities; or (2) PAACA has reasonable cause to terminate the tenancy due to a change or changes in any federal funding guidelines which may affect any provisions of the lease ***or*** PAACA in its sole discretion decides to terminate operation of the program (including but not limited to the sale of the property as set forth below), *or* PAACA's Landlord terminates PAACA's lease agreement.

4. UTILITIES: This lease **does NOT include** the cost of any utilities, which are the TENANT's sole responsibility.

5. USE OF PREMISE: Only the TENANT who signs this Lease shall live in the property. NO OVERNIGHT GUEST ARE PERMITTED without the express written consent of PAACA.

THE PARTIES HERETO, IN CONSIDERATION OF THESE PRESENTS, AGREE AS FOLLOWS:

1. No more than _ authorized adult persons will occupy said premises.

2. No pets or other animals (including service animals) may be brought onto or kept by TENANT without the express written consent of PAACA.

3. TENANT agrees to comply with all the requirements imposed under the Terms of Contract with PAACA dated, _____ , including but not limited to remaining drug and alcohol-free. Noncompliance with the Terms of Contract shall confer to PAACA the right to terminate the Contract and this Lease.

4. TENANT will obey all laws and Ordinances of the United States, Massachusetts, and the City of New Bedford.

5. TENANT will **not** smoke or vape in the unit or the building.

6. TENANT will not allow persons on the premises without the express permission of PAACA. Neither TENANT nor authorized guests will engage in conduct that will disturb other building residents or neighboring properties.

7. That TENANT shall make no alteration, addition, or improvement to the leased property without the written consent of PAACA. Any alteration, addition, or improvement made by TENANT after such consent shall have been given, and any fixtures installed as part thereof shall remain the property of PAACA upon the expiration or other earlier termination of this lease.

8. PAACA hereby notifies TENANT that Carl Alves and Albie Cullen are the persons authorized to receive notices on behalf of the PAACA and to accept service of process on behalf of the PAACA.

9. TENANT shall maintain the leased premises cleanly, and TENANT will be responsible only for damage, breakage, or waste not considered normal wear and tear. Upon termination of this lease, TENANT will be responsible for leaving the premises in the same general, good, habitable, and broom-clean condition as found upon entry.

10. If the unit's OWNER decides to sell the property to a qualified purchaser during this leasehold period, PAACA can terminate the lease agreement.

11. It shall be the TENANT'S sole obligation to ensure the safety and security of the TENANT'S personal property, and the keeping of said personal property shall be at the sole risk of the TENANT.

12. Any notice by either party to the other shall be in writing and shall be deemed to be duly given only if delivered personally or mailed by registered or certified mail, addressed to PAACA as Positive Action Against Chemical Addiction, Inc., 360 Coggeshall Street, New Bedford, MA 02746, and to the **TENANT** at the address noted on this Lease unless either party has notified the other party in writing of a change of address for notice.

13. During the lease term, the **TENANT** will keep and maintain the leased premises in such good repair, order, and condition as at the commencement hereof, reasonable wear and tear and damage by unavoidable casualty included. **PAACA** shall make all repairs, changes, alterations, and additions which may be required by any laws, ordinances, orders, or regulations of any public authorities having jurisdiction over the leased property, except that PAACA will NOT make such repairs, changes, alterations, and additions required because of any use made of the leased property by TENANT other than the proper and lawful use as a private residence, or because of any unlawful action or any negligence of the TENANT or any breach or default by TENANT under this lease

14. The waiver by either party of a breach of any term, condition, covenant, obligation, or agreement of this lease shall not be considered a waiver of that or any other term, condition, covenant, obligation, or Agreement or any subsequent breach thereof.

By signing this Agreement, both parties stipulate a complete understanding of the terms and provisions herein to this lease agreement. The parties also stipulate receiving an executed (signed) copy of this Agreement.

IN WITNESS WHEREOF, the parties hereunto set their hand and seals on this day.

By the TENANT:

_____

DATED:_____

By PAACA:

_____
Carl J. Alves President/CEO PAACA
PAACA
360 Coggeshall Street
New Bedford, MA 02746

DATED:_____

EXHIBIT A

PAACA PSH Program
This lease DOES NOT include utilities

Step Up Housing Rules and Regulations

1. TENANT agrees to work with TENANT's assigned caseworker to design and monitor an Individual Service Plan and to sign any required Releases of Information associated with this process.
2. TENANT agrees to have regular and consistent contact with TENANT's assigned caseworker (no less than once per week) regarding implementing TEANT'S ISP and make ongoing adjustments as needed.
3. TENANT understands that as part of his/her participation with the Step Up Housing Program, TENANT is to be either gainfully employed, in school/taking classes, or volunteer within the local community or at PAACA.
4. Upon acceptance into the Step Up Housing Program, TENANT agrees to abide by all expectations and Program rules. TENANT understands and agrees that any violation of this agreement may result in termination from the Program and filing an eviction proceeding.
5. Examples of inexcusable activities and behaviors include but are not limited to:
    - Illegal drug use (including prescription drugs) or drug dealing,
    - Any threats of violence or violent behavior,
    - Theft or destruction of property,
    - Prostitution,
    - Arson,
    - Unlawful possession of a firearm;
    - Subletting or assigning this lease in whole or in part; and
    - Any of TENANT's guests engaging in these activities.
6. TENANT understands that this Program is not liable or responsible for the loss or theft of his/her personal property or any personal injury that may occur on the premises of my PAACA Step Up Housing Program residence.
7. The Program staff will keep all personal information confidential, including but not limited to any health issues, unless they receive TENANT's prior written consent to release any information.
8. TENANT understands that PAACA must share personal information internally and with other providers on an "as needed" basis. TENANT agrees to sign any releases of information necessary to obtain services that TENANT requests or implement any recommended and agreed-upon treatment.
9. TENANT will only admit persons into the building whom TENANT knows to be safe and non-threatening to TENANT and others residing in the building.
10. TENANT agrees to respect the privacy of other residents in this Program and keep their identity, living address, and any other information TENANT might acquire about their health or life circumstances confidential.
11. TENANT will execute legal documents, including a health care proxy, should they become necessary to ensure the proper handling of TENANT's practical health concerns, personal property, and general well-being.
12. TENANT agrees to maintain the housing unit and assume all costs associated with any damages incurred by TENANT or any guests/visitors TENANT has allowed into the building. TENANT agrees to submit a complete damage assessment within seven (7) days of moving into the Unit.
13. TENANT understands that NO PETS are allowed in the housing program. This policy includes, but is not limited to, dogs, cats, snakes, turtles, guinea pigs, birds, spiders, etc.
14. TENANT understands that TENANT is not allowed to bring any furniture into the Unit in poor condition or may cause a health/safety risk to me or anyone else living in the building (including but not limited to furniture found on the side of the road.
15. TENANT agrees to submit to random drug testing at any time (but no less than once per week) as requested by program staff.

16. TENANT agrees if TEANANT tests positive for any substance, TENANT's continued participation in the program may be contingent on participation in Substance Use Disorder Treatment, including but limited to long-term inpatient treatment.
17. TENANT agrees to submit to random unannounced home visits.
18. TENANT will not allow anyone who Step-Up has previously discharged on the premises of any Step-Up Housing properties.
19. TENANT understands this housing is not permanent, and TENANT will continue seeking other permanent, suitable housing opportunities, including but not limited to applying to other programs through the Housing Authority and similar agencies.
20. If TENANT is offered any subsidy or accepted into any Housing Authority property, TENANT must take the subsidy or unit. Not doing so will result in termination and eviction from this Program.
21. TENANT understands that if Step-Up terminates tenancy or TENANT chooses to leave the Step-Up Housing Program voluntarily, TENANT will have seven days to remove all belongings.
22. After seven days, TENANT authorizes PAACA to remove any belongings and dispose of them at PAACA's sole discretion.

_____ _____
Tenant Signature Date

_____ _____
Staff Signature Date

Informed Consent

TENANT acknowledges that TENANT has had the opportunity to ask any questions concerning this agreement.
TENANT has either read or had this agreement read to them, and TENANT fully understands and agrees to all of its terms.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

CONTRACT OF PARTICIPATION

SEMCOA Inc operates its Transitional Support Program (TSP) (the "Program") at 72 Kilburn Street in New Bedford, Massachusetts as a program of recovery and opportunity sponsored by the U.S. Department of Housing and Urban Development ("HUD") and contracted by BSAS for Housing and Homelessness Supportive Case Management services. It is SEMCOA's mission to empower homeless and at risk of homelessness individuals and families to grow personally, obtain employment, pursue further training/education, develop parenting/life skills, and strengthen and maintain their recovery. TSP is a structured program focused on assisting Participants in maintaining sobriety, gain employment, and optimize self-sufficiency. This agreement describes the responsibilities of TSP and the Program participant ("Participant") with respect to services offered as part of the Program. The Participant signing this Contract of Participation will sign or has signed a separate Occupancy Agreement with respect to Unit **0**(the "Unit") at 1 Smith Street, New Bedford, Massachusetts

I understand that TSP is a program funded by both HUD and the Bureau of Substance Abuse Services (BSAS) and managed by the City of New Bedford. I understand TSP is required to collect financial documentation on an annual basis and agree to readily provide such documentation.

Services and Activities

As soon as possible, but in any event within 3 days after I first occupy the Unit, I will meet with a TSP case manager to identify needs and goals to be addressed through educational and supportive services. Based on our discussions, the Case Manager and I will work together to create a treatment plan within 7 days after I first occupy the Unit and begin participation in the Program.

The Treatment Plan is an ongoing document that is regularly updated and reviewed to reflect goals obtained and/or revised and will be attached to and made a part of this Contract of Participation. I understand that I ***must*** meet with my case manager and sign my Treatment Plan within 7 days after I first occupy the Unit.

I agree to participate in the activities outlined in my Treatment Plan, including (1) the educational and supportive services to be offered by TSP and others as part of the Program, and (2) a range of other activities, as outlined in my Service Plan (the "Outside Activities"). Transitional housing focuses on sobriety, employment and self-sufficiency and my treatment plan will reflect these activities.

A. Program.

Program requirements and services include:

- Case management services to be provided by TSP as well as a 24-hour contact phone number;
- Educational workshops addressing issues including, but not limited to, substance use, mental health, income, parenting, employment, housing, health, education and money management;
- Recovery activities such as AA, NA, Smart Recovery meetings;

- Daily psychoeducational groups that address recovery from substance use and/or mental health, trauma, and related issues;
- Job search assistance;
- Referrals for computer training through separate vendor (ie, MassHire);
- Ongoing peer support and recovery activities as well as groups and workshops to develop the life skills necessary to develop economic and emotional stability and clear personal goals;
- Referrals for child care through a separate vendor;
- Other services or activities as stated by the Service Plan.

I understand that I will be expected to meet weekly with my Case Manager and to attend psychoeducational groups, educational groups, and workshops that fulfill the needs identified in the Treatment Plan, with the specific requirements to be agreed upon by myself and my Case Manager and outlined in detail in my Treatment Plan.

I further understand that TSP may not provide services specifically designed to address certain mental or physical disabilities. If I have a mental or physical disability and require special services in order to access housing or other services, TSP will help me to identify and contact appropriate mental and physical health providers to provide such services.

B. Other Activities. As part of my Treatment Plan, my case manager and I will agree upon a set of additional activities that are important to my particular needs and goals but are not provided or coordinated by TSP ("Outside Activities") in which I will be expected to participate. By way of example only, Outside Activities may include:

- Educational programs such as high school equivalency program, adult basic education, college-level courses, or job training programs;

- Part-time or full-time employment and/or volunteering (All participants will be expected to engage in one of these activities within 90 days of entry to the program with exceptions for those enrolled in job training/educational programs or other activities deemed necessary by the program director;

- Participation in support groups such as Grief Support, Anger Management, Domestic Violence, etc.

Active Participation; Compliance with Program Rules

I understand that, in order to enjoy the privilege of being part of the Program, I must participate actively in the Program and must comply with rules and regulations (see Occupancy Agreement & Program Rules). Failure to participate may result in my termination from the Program.

Confidentiality

I authorize TSP to discuss relevant details of my participation in the Program with other service providers with a release of information in place. I agree to maintain the confidentiality of other

Program participants. I will not discuss other Program participants or their personal information with anyone outside the Program. I will not share information or photographs on social media or anywhere online regarding other participants of the Program.

Transitional Planning

My Case Manager will assist me in developing and implementing my Treatment Plan goals. My Treatment Plan and my Aftercare Plan will help me achieve my goal for a positive transition when I leave and cease participation in the Program. Upon leaving, I will receive a resource directory of services available in the community, copies of important documents contained in my file (birth certificates, social security cards, insurance cards, etc.) and any other documents that my case manager deems necessary. TSP will help me to locate items that I need for independent living. Current service providers will be notified of my discharge, and I will have the opportunity to continue services that are in place. I understand that SEMCOA offers additional aftercare services, including parenting support, emotional support, and linkage to community resources.

Failure to Participate

This Contract of Participation is a contract and is part of my Occupancy Agreement for the Unit. I understand that if I do not agree to a Treatment Plan within the time periods described on page 1 of this Contract, or if I fail to participate in the addiction services and program activities agreed upon by myself and the case manager, or if I fail to comply with my Occupancy Agreement, TSP may terminate my Occupancy Agreement after following the procedures for termination described in the Occupancy Agreement.

By signing below, I agree to abide by all of the requirements of this Contract of Participation.

_____

PROGRAM PARTICIPANT SIGNATURE DATE

_____

PROGRAM PARTICIPANT SIGNATURE DATE

_____

TSP CASE MANAGER, SEMCOA DATE

_____

DIRECTOR OF HOUSING DATE

1C-10
ATTACHMENT

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

Attachment includes a copy of the MA-505 CoC's Public Safety Coordination and Non-Interference Policy as well as a letter from Police Chief Jason Thody.

MA-505 CoC's Public Safety Coordination and Non-Interference Policy

The Bristol County Continuum of Care (CoC) recognizes that effective coordination among homeless service providers, law enforcement, behavioral health providers, and other community partners is essential to promoting public safety while ensuring that individuals and families experiencing homelessness can access housing and supportive services.

Throughout the CoC geography, CoC recipients, subrecipients, and participating agencies are encouraged to maintain constructive working relationships with local law enforcement and public safety partners, including through coordinated crisis response, referrals, information sharing consistent with applicable privacy requirements, and connection to behavioral health, housing, and other appropriate services. Examples include collaboration with community-based crisis response teams, such as HEART Teams and Community Crisis Intervention Teams (CCIT), where available.

At the same time, law enforcement and public safety activities should not interfere with the CoC's lawful efforts to provide outreach, shelter, housing, Coordinated Entry, and supportive services. CoC programs will not condition access to housing or services on cooperation with law enforcement except where specifically required by applicable law. The CoC and its participating agencies will continue to promote approaches that address legitimate public safety concerns while protecting access to housing and services and respecting the rights and privacy of people experiencing homelessness.

The CoC will periodically review coordination with public safety partners and encourage communication and collaborative problem-solving across the full Bristol County CoC geography to strengthen both community safety and housing stability.

Adopted by a vote of the Executive Board

September 21.2026

New Bedford Police Department
Office of the Chief of Police

871 Rockdale Avenue, New Bedford, MA 02740
Phone: 508-991-6300

Jonathan F. Mitchell
Mayor

Jason Thody
Chief of Police

Derek J. Belong
Deputy Chief

Scott A. Carola
Assistant Deputy Chief

September 20, 2026

To Whom It May Concern:

On behalf of the New Bedford Police Department, I am pleased to provide this letter of support for the Bristol County Continuum of Care (CoC) and its efforts to address homelessness while advancing public safety throughout our community.

The New Bedford Police Department maintains an active and collaborative relationship with the CoC and its homeless service providers. Our Department works with the CoC and community partners to address situations in which homelessness, behavioral health, substance use, and public safety concerns intersect, with an emphasis on appropriate referrals, coordinated responses, and connection to housing and supportive services.

A key example of this collaboration in New Bedford is the HEART Team, which works in coordination with law enforcement and community service providers to respond to individuals experiencing behavioral health or other crises, particularly those in encampments, and connect them with appropriate services. The Department also participates in the Community Crisis Intervention Team (CCIT), working alongside the CoC and other community partners to strengthen coordinated crisis response and improve connections to behavioral health, housing, and other supportive resources.

The New Bedford Police Department supports the CoC's efforts to provide housing and services through Coordinated Entry and other community-based programs. The Department does not interfere with the CoC's lawful efforts to provide housing, shelter, outreach, or supportive services. Instead, **we recognize that collaboration among law enforcement, housing providers, behavioral health organizations, and other community partners is essential to promoting both public safety and the well-being of individuals and the broader community.**

We are committed to continued coordination with the Bristol County CoC and its participating agencies and to supporting collaborative approaches that promote safety, stability, and appropriate access to services for individuals and families experiencing homelessness.

Sincerely,

Jason Thody
Chief of Police

1D-1
ATTACHMENT

Local Competition Scoring Tool

CoC Project Selection Process

Application Selection Process, Scoring, Ranking, and Reallocation Process 2026

Project Selection

The process for selecting and scoring projects first includes a threshold review requirement, a merit review with project scoring and responses to any requests for explanations. The CoC's Performance Review Committee (PRC) may also seek more information and/or require a brief presentation by the applicant to the PRC, itself. Once all reviews are complete and scoring has been done, the process ends with the PRC presenting its recommended ranking to the Bristol County CoC (BCCC) membership who then votes for the final ranking of projects.

All applications will be reviewed to ensure both threshold and merit requirements for both renewal projects and new projects are met.

Threshold

Threshold Review. The City of New Bedford's Office of Housing & Community Development (OHCD) as collaborative applicant on behalf of the BCCC will complete the threshold review for all submitted applications. The OHCD will then provide all information necessary for scoring each application meeting the threshold requirements to the PRC.

Applicants must meet <u>threshold eligibility requirements</u> to be considered eligible:

- Project eligibility threshold (both renewal and new projects),
- CoC Program eligibility requirements and evidence of that eligibility as required in the application (such as nonprofit documentation),
- Financial management capacity (with experience to carry out the project and capacity to administer federal funds),
- Projects must serve populations meeting the program eligibility requirements (as described in the Act, the Rule and Section III G.11 of the HUD CoC NOFO,
- Project applicants must agree to participate in the BCCC's local HMIS system (except for victim service providers who must instead use a comparable database meeting the needs of the BCCC's HMIS,
- Project applicants must submit the required certifications specified in the NOFO,
- Project applicants must certify affirmatively that they will:
  - Not engage in illegal racial discrimination,
  - Not operate a drug injection site or safe consumption site.

Each project, whether new or renewal, must demonstrate how it will meet the scoring criteria. Please note that some criteria noted may not be applicable to all project types.

Agencies that do not meet the threshold score or who are not recommended for funding or reduced funding may appeal and address the members of the COC PRC based only on the guidelines established by the BCCC. (agencies recommended or only partially funded are <u>not</u> eligible to request an appeal).

Project Eligibility

Applicants meeting threshold eligibility must then meet project eligibility and merit requirements to be considered eligible. The OHCD and/or the CoC's PRC reserve the right to request additional and/or clarifying information to inform its review of a project.

A detailed review of each project meeting threshold requirements is made by the PRC who will consider all aspects of the prospective submission including, but not limited to, the intended project eligibility, itself, intended project participant eligibility, program configuration, programming requests compared against federal and local needs and priorities and responses to all questions within the application including narrative responses focusing on HUD priorities.

After consultation and analysis, will render scoring for each project.

Detailed Project Review

The PRC will complete the review, scoring and evaluation process using the scoring rubrics provided in this document.

In the case of renewal applications...
...the scoring rubric evaluates past performance and practices that will improve the BCCC's system response to homelessness and align this response with national policies and best practices..

In the case of new applications and DV bonus applications...
...the scoring rubric evaluates practices that will improve the BCCC's system response to homelessness and align this response with national policies and best practices.

Scores will determine each project's rank in the CoC's application to HUD and rank will be the primary determinant of placement into Tier 1 and Tier 2. Scores may also be used to reject applications or to reduce budgets for low-scoring projects or over-funded projects.

Final Selection/Ranking

After scoring the application, the PRC will present its resulting ranking recommendation for funding approval to the BCCC membership meeting after which a vote will be taken on ranking of projects to be submitted to HUD.

If a project is not selected for funding, the applicant has the right to appeal, provided that the appeal is based upon violations of program regulations. For example, reviewing members did not consistently follow the scoring criteria and process or if there was a conflict of interest that prevented a fair review of the proposal. No appeals will be heard based on funding level. Appeals must be made consistent with the NOFO.

Scoring

As noted within the application for funding, itself, all applications will be reviewed to ensure both threshold and merit for both renewal projects and new projects.

1. **Applicants must meet threshold eligibility requirements to be considered eligible:**
   - Project eligibility threshold (both renewal and new projects),
   - CoC Program eligibility requirements and evidence of that eligibility as required in the application (such as nonprofit documentation),

- Financial management capacity (with experience to carry out the project and capacity to administer federal funds),
- Projects must serve populations meeting the program eligibility requirements (as described in the Act, the Rule and Section III G.11 of the HUD CoC NOFO,
- Project applicants must agree to participate in the BCCC's local HMIS system (except for victim service providers who must instead use a comparable database meeting the needs of the BCCC's HMIS,
- Project applicants must submit the required certifications specified in the NOFO,
- Project applicants must certify affirmatively that they will:
    - Not engage in illegal racial discrimination,
    - Not operate a drug injection site or safe consumption site.

Each project, whether new or renewal, must demonstrate how it will meet the scoring criteria identified in the application and in this document. Please note that some criteria noted may not be applicable to all project types.

2. **Applicants must meet <u>project eligibility requirements</u> to be considered eligible:**

<u>Renewal Project Thresholds</u>
The BCCC will consider the need to continue funding any project expiring in calendar year 2027 that seeks to continue as a renewal project in the FY2026 round and the extent to which the potential renewal project has/will improve the efficacy of the CoC's efforts to end homelessness. HUD will consider project information from eLOCCS, APRs and any information from the HUD CPD Field Office including monitoring reports and audit reports and performance standards achieved on prior grants. HUD will assess submitted project applications on a pass/fail basis as further detailed in the NOFO at Section V A. 4. b.

New Project Thresholds
The BCCC will consider applications for new funding that meet the new project thresholds detailed on the BCCC Competition site and in the NOFO at Section V.A.4.c.3.and 4. Please note that project applicants must demonstrate their ability to meet all timeliness standards and project quality thresholds for the project type for which application is made. Specific criteria and new project application rating factors being considered are detailed in the NOFO at Section V A.4.

New Projects/DV Bonus Projects

Consideration for funding of new/DV bonus projects funded out of the CoC Bonus and/or including those created as a result of reallocation, will be based on the following performance objectives:

- Agency Experience and Capacity (20 point maximum)
- Project Quality and Alignment (60 point maximum)
- Match Resources (10 point maximum)
- Fiscal Management (10 point maximum)

New and bonus projects may score up to 100 points maximum based on information provided in the application including attachments of required materials. Specific scoring criteria for new/bonus projects is as follows:

Scoring Criteria :: New / Bonus DV Projects	
STANDARDS AND SCORING	**MAX POINTS**
Agency Experience and Capacity. Applicants with experience in administering HUD or other federal funds successfully and providing the proposed service and/or serving the proposed population, demonstrating that the proposed project will fill an existing gap within the CoC and/or that it propels the CoC forward toward improving its system performance and meeting its goal of ending homelessness will receive up to 20 points.	**20**
Project Quality. Each application will be scored on the overall quality of the project, and the extent to which the applicant can clearly demonstrate the following: ▪ Proposed Project/Need (12 points): Applicants may receive up to 15 points based on its evidence of community need, the extent to which the project aligns with HUD priorities, the extent to which applicant has ongoing collaborations within the community, and extent of leverage (particularly private funding resources). ▪ Proposed Population To be Served (6 points): Projects proposing to have at least 100% of beds dedicated to chronic homeless will receive 6 points. Applicants seeking DV Bonus funding may receive an additional 2 points when clearly demonstrating project participants will meet DV Bonus participant eligibility. ▪ Alignment with HUD Priorities (42 points): Points will be awarded based on a proposed project's ability to advance recovery, optimizing self sufficiency and restricting taxpayer funded illicit drug use or paraphernalia distribution, as well as the extent to which the project has integrated on-site substance use treatment, faith-based and/or non-traditional service provider relationships and public safety/law enforcement partnerships as described through narrative responses. (Six questions valued at 7 points each).	**60**
Match Resources. Projects demonstrating ability to match the required HUD 25% match will receive up to 8 points; those projects leveraging 25-50% non-government funding will receive the full 10 points.	**10**
Fiscal Management. To receive maximum points, applicants must demonstrate history of financial stability, including prompt expenditure of program funds, and no outstanding audit or HUD monitoring findings.	**10**
TOTAL POSSIBLE POINTS for NEW PROJECTS / BONUS DV PROJECTS	**100**

Renewal Projects

Consideration for funding of renewal projects will be based on the scored submitted application, objective scoring criteria from HMIS, SimTech performance dashboards and 12 month APR reporting, percentage drawdowns during the current program year cycle through the HUD LOCCS system, and monitoring results from the OHCD and/or HUD. The following performance objectives will be used to score renewal projects:

- Performance (50 point maximum)
- Data Quality (4 point maximum)
- Fiscal Management (10 point maximum)
- Narrative Responses (36 point maximum)

In addition to these scored elements, all renewal projects will be expected to satisfy additional evaluation criteria noted within this section. Renewal projects may score up to 100 points maximum based on information provided in the application including attachments of required materials. Specific scoring criteria for renewal projects is as follows:

Scoring Criteria :: Renewal Projects			
GOALS	**PERFORMANCE STANDARD**	**SCORING**	**MAX POINTS**
1. Housing Stability Persons residing in PSH or PSH-RRH who exited to another permanent housing destination. Goal 85%	Based on APR Q1 & Q23c The % of persons who exited to permanent housing destinations as of the end of the operating year.	≥85%=10 80%-84%=9 65%-79%= 7 55%-64%= 3 ≤54%= 0	**10**
2. Returns to Homelessness Persons exiting permanent housing will not return to homelessness (Including Transitional Housing) Goal <10%	Based on APR Q1 & Q23c The % of persons in the PSH program returning to homelessness shall be less than 10%.	<0% - <2% = 5 <3% - <5% = 3 <6% - <8% = 2 <9% =1 <10%= 0	**5**
3. Earned Income – Stayers Adult stayers will increase earned income (employment income). Goal 10%	Based on APR Q19a1 – Adults with Earned Income The % of persons ages 18 or older staying in the program who increased their income (employment income) as of the latest annual assessment.	≥10%= 5 9%-7%= 4 6%-4%= 3 3%-2%= 2 ≤1%= 0	**5**
4. Non-Employment Cash Income – Stayers Adult stayers will increase non-employment cash income (mainstream resources). Goal 40%	Based on APR Q19a1 – Adults with Other Income The % of persons ages 18 or older staying in the program who increased their non-employment cash income (mainstream resources) as of the latest annual assmnt. t	≥40%= 5 30%-39%= 4 20%-29%= 2 ≤20%= 0	**5**
5. Earned Income – Leavers Adult leavers will increase earned income (employment income). Goal 20%	Based on APR Q19a2 – Adults with Earned Income The % of persons ages 18 or older leaving the program who increased their income (employment income) by program exit.	≥20%= 5 14%-19%= 4 7%-13%= 3 2%-6%= 2 ≤1%= 0	**5**
6. Non-Employment Cash Income – leavers Adult leavers will increase non-employment cash income (mainstream resources). Goal 50%	Based on APR Q19a2 – Adults with Other Income The % of persons ages 18 or older leaving the program who increased their non-employment cash income (mainstream resources) by program exit.	≥50%= 5 36%-49%= 4 21%-35%= 2 ≤20%= 0	**5**
7. Utilization Rate - Beds Program operates at full capacity, with low vacancy rate, and quickly fill vacancies. Goal 90%	Based on APR Q8b Average quarterly utilization rate during the operating year.	≥90%= 10 70%-89%= 8 51%-69%= 5 ≤50%= 0	**10**
8. Data Quality Agency's thoroughness in ensuring all data is collected and entered into HMIS. Goal = No Omissions	Based on APR Q2, Q3, Q4, Q5	0 oms= 4 1%-10%= 3 11%-20%= 2 21%>= 0	**4**
9. Chronic Homeless - Persons Persons who are chronically homeless by household Goal 100%	Based on APR Q26b The # of chronically homeless persons divided by the total number of persons served.	Prorated up to 5 points for 100% of CH Beds.	**5**

10. Fiscal Management Complete and timely drawdown of funds. Goal = 100% Drawdown	Based on HUD LOCCS		0%=10 1%-5%= 8 6%-10%= 5 10%>= 0	**10**
11.Narrative Responses. Applicant responses to the six narrative questions (items #B15 A – B15 F in the application) and will each be scored with a cumulative total of 36 points possible.			Up to 6 points per question possible	**36**
			TOTAL POSSIBLE POINTS	**100**

Additional Evaluation Criteria
Renewal projects will also be evaluated based on the following baseline criteria. Subrecipients that fail that meet these required criteria will lose points.

Additional Evaluation Criteria*
Agency Experience and Capacity. ▪ Administration: Applicants demonstrating extensive experience in administering HUD or other federal funds and providing the proposed service and/or serving.
Fiscal Management. ▪ Applicants must demonstrate history of financial stability, including prompt expenditure of program funds, and no outstanding audit or HUD monitoring findings.
Project Quality. ▪ Refocus Away from Housing First: Applicants will be evaluated to the extent to which the project is emphasizing accountability, intensive mental health and addiction treatment while optimizing income and long term self-sufficiency. ▪ Consistency of Program: Applicants will be evaluated to the extent to which the project's performance is consistent against plans and goals established in the application.

*The presence of all threshold criteria is also part of the additional evaluation criteria.

Ranking

HUD requires that all CoCs list all projects that they approved to submit project applications to HUD, in the order of priority as determined by the CoC. CoCs should place all new and renewal project applications that the CoC determines are high priority, high performing, and meet the needs and gaps as identified by the CoC in Tier 1. HUD will select projects in Tier 1 as described in the NOFO. HUD will select all projects in Tier 1 before selecting any projects in Tier 2. Then, HUD will select projects in Tier 2 as described in the NOFO. Lower ranked projects may be selected for funding above higher ranked projects, consistent with HUD's selection priorities.
The CoC renewal application components and narratives serve to:

- Confirm the capacity of agencies to provide CoC funded programs;
- Provide information on program delivery in order to evaluate performance and meeting HUD priorities for scoring and ranking of projects by the PRC; and
- Provide project level narrative to be utilized in the CoC Collaborative Application. HUD will limit renewal grants to one (1) year of funding. Renewal Project Applications that request multiple years of funding will be reduced to one (1) year grant amounts.

Renewal projects must meet minimum project eligibility, capacity, timeliness, and performance standards. HUD will review information in the LOCCS; Annual Performance Reports (APRs); and information provided from the HUD local /CPD Field

Office, including monitoring reports and Part 200 audit reports as applicable, as well as performance standards on prior grants, and assess a project on the following criteria using a pass/fail basis:

- Applicant's performance against plans and goals;
- Timeliness standards;
- Applicant's performance in assisting program participants to achieve and maintain independent living and record of success;
- Financial management accounting practices;
- Timely expenditures;
- Capacity;
- Timeliness; and
- Eligible activities.

Reallocation Process

The U.S. Department of Housing and Urban Development (HUD) requires that CoCs careful evaluate and review all renewal projects and to develop a reallocation process for projects funded with CoC funds. Reallocating funds is an important tool used by CoCs to make strategic improvements to their homelessness system. Through reallocation, the CoC can create new projects that are aligned with HUD's goals, by eliminating projects that are underperforming or are more appropriately funded from other sources. Reallocation is particularly important when new resources are not available.

The Bristol County CoC relies on this reallocation process in determining funding to ensure highest performing projects and those that can positively affect system performance throughout the continuum receive reallocated funding from lower-performing projects.

A copy of the BCCC's Reallocation Process is available online at BCCC Competition site.

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Local Competition Selection Results

LOCAL COMPETITION SELECTION RESULTS 2026

RANK	PROJECT NAME *and* APPLICANT	PROJECT TYPE	SCORE	STATUS	REQUESTED FUNDING AMOUNT	REALLOCATED FUNDS
NOT RANKED	**COC PLANNING PROJECT**	PLNG.	N/A	ACCEPTED	$ 252,698.00	N/A
1	**CITY OF NEW BEDFORD HMIS PROJECT 2.0** *City of New Bedford*	HMIS	99	ACCEPTED	$ 83,600.00	$ 83,600
2	**THE CALL BCCC** *CCBC*	NEW SSO-CE	98	ACCEPTED	$ 219,116.00	$219,116
3	**HOMES WITH HEART II** *CCBC*	NEW PSH	96	ACCEPTED	$ 408,095.00	$340,880
4	**FAMILY PRESERVATION PROGRAM II** *SEMCOA*	NEW PSH	96	ACCEPTED	$ 163,564.00	$130,851
5	**NB PERMANENT HOUSING PROJECT** *Steppingstone*	NEW PSH	96	ACCEPTED	$ 241,650.78	$172,607
6	**SEMCOA TRANSITIONAL SUPPORT PROGRAM** *SEMCOA*	NEW TH	95	ACCEPTED	$ 369,776.00	$308,146
7	**TRANSITION TO HOME** *CCBC*	NEW TH	94	ACCEPTED	$ 655,970.00	$524,776
8	**NB TRANSITIONAL HOUSING PROJECT** *Steppingstone*	NEW TH	93	ACCEPTED	$ 391,100.23	$312,880
9	**RECOVERY WORKS TRANSITIONAL HSG PROG** *PAACA*	NEW TH	92	ACCEPTED	$ 357,113.00	$357,113
10	**NB STREET OUTREACH PROGRAM** *City of New Bedford*	NEW SSO-SO	88	ACCEPTED	$ 250,000.00	$250,000
11	**NORTHERN BRISTOL COUNTY STREET OUTREACH** *CCBC*	NEW SSO-SO	87	ACCEPTED	$ 217,250.00	$173,800
12	**STEPPINGSTONE STREET OUTREACH PROJECT** *Steppingstone*	NEW SSO-SO	86	ACCEPTED	$ 397,587.16	$150,000
13	**TWC BRISTOL COUNTY TRANSITIONAL HOUS.PROG** *New Bedford Women's Center*	NEW DV TH	85	ACCEPTED	$ 263,676.00	$256,225
14	**TWC BRISTOL COUNTY SUPPORTV SRVCS** *New Bedford Women's Center*	NEW DV SSO-CE	78	ACCEPTED	$ 121,652.96	$121,652
NOT RANKED	**FAMILY PRESERVATION PROGRAM** *SEMCOA*	PSH	-	FULLY REALLOCATED	$0	($543,746)
NOT RANKED	**STEP UP** *PAACA*	PSH	-	FULLY REALLOCATED	$0	($397,707)
NOT RANKED	**HOMES WITH HEART** *CCBC*	PSH	-	FULLY REALLOCATED	$0	($857,064)
NOT RANKED	**WELCOME HOME** *Steppingstone*	PSH	-	FULLY REALLOCATED	$0	($471,631)
NOT RANKED	**PORTICO** *CCFR*	PSH	-	FULLY REALLOCATED	$0	($812,732)
NOT RANKED	**STEADFAST** *CCFR*	PSH	-	FULLY REALLOCATED	$0	($185,299)
NOT RANKED	**THE CALL COMBINED** *CCBC*	SSO-CE	-	FULLY REALLOCATED	$0	($133,929)
NOT RANKED	**THE CALL EXPANSION** *CCBC*	SS0-CE	-	FULLY REALLOCATED	$0	($ 85,187)
NOT RANKED	**GREEN LIGHT PROJECT** *PACE*	PSH	-	FULLY REALLOCATED	$0	($168,136)
NOT RANKED	**STEP UP RAPID REHOUSING** *PAACA*	RRH	-	FULLY REALLOCATED	$0	($108,435)

2A-8b
ATTACHMENT

FY2026 HDX Competition Report

2026 Competition Report - PIT Summary

MA-505 - New Bedford CoC

For PIT conducted in January/February of 2026

Submission Information

Date of PIT Count	Received HUD Waiver
1/28/2026	Not Applicable

Total Population PIT Count Data

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Emergency Shelter Total	938	946	308
Safe Haven Total	0	0	0
Transitional Housing Total	82	78	82
Total Sheltered Count	1,020	1,024	390
Total Unsheltered Count	159	101	108
Total Sheltered and Unsheltered Count*	1,179	1,125	498

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

Total People Experiencing Chronic Homelessness

Category	2024	2025	2026
PIT Count Type	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count	Sheltered and Unsheltered Count
Total Sheltered Count	81	37	46
Total Unsheltered Count	45	40	49
Total	126	77	95

2026 HDX Competition Report

This workbook contains summary information about your CoC's data as it was entered into the HDX for your use as part of the 2026 Competition.

To Print this Workbook:

This document has been configured as printable with preset print areas of relevant sections. To print it, go to "File", then "Print", then select "Print Entire Workbook" or "Print Active Sheets" depending on your needs.

To Save This Workbook as a PDF:

Click the "File" Tab, then click "Save As" or "Save a Copy", then click "Browse" or "More Options" then select "PDF", click "Options", select "Entire Workbook", press "OK", and click "Save". These instructions may differ depending on your version of Microsoft Excel.

On Accessibility, Navigability, and Printability:

This workbook attempts to maximize accessibility, navigability, printability, and ease of use. Merged cells have been avoided. All tables and text boxes have been given names. Extraneous rows and columns outside printed ranges have been hidden.

For Questions:

If you have questions, please reach out to HUD via the "Ask a Question" page, https://www.hudexchange.info/program-support/my-question/ and choose "HDX" as the topic.

2025 HDX Competition Report

2026 Competition Report - Summary

MA-505 - New Bedford 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

MA-505 - New Bedford CoC

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

LSA Usability Status 2025

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

Glossary: EST = Emergency Shelter, Save Haven, & Transitional Housing; RRH = Rapid Re-housing; PSH = Permanent Supportive Housing; AO = Persons in Households without Children; AC = Persons in Households with at least one Adult and one Child; CO=Persons in Households with only Children
*Usability was not determined for PSH-AC due to built-in conflicts between HOMES and HMIS. As

2026 Competition Report - SPM Data

MA-505 - New Bedford 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	0	0.0	0.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	1,834	266.6	227.0

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.

2026 Competition Report - SPM Data

MA-505 - New Bedford CoC

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

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")	0	0.0	0.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to "housing move in")	1,866	448.6	370.0

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**	**Count**	**% of Returns**
Exit was from SO	70	8	11.4%	1	1.4%	8	11.4%	17	24.3%
Exit was from ES	252	4	1.6%	6	2.4%	2	0.8%	12	4.8%

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Exit was from TH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	197	0	0.0%	3	1.5%	0	0.0%	3	1.5%
TOTAL Returns to Homelessness	519	12	2.3%	10	1.9%	10	1.9%	32	6.2%

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	1,842
Emergency Shelter Total	1,842
Safe Haven Total	0
Transitional Housing Total	0

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

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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)	149
Number of adults with increased earned income	23
Percentage of adults who increased earned income	15.4%

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)	149
Number of adults with increased non-employment cash income	70
Percentage of adults who increased non-employment cash income	47.0%

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

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Metric	Value
Universe: Number of adults (system stayers)	149
Number of adults with increased total income	87
Percentage of adults who increased total income	58.4%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	29
Number of adults who exited with increased earned income	5
Percentage of adults who increased earned income	17.2%

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

Metric	Value
Universe: Number of adults who exited (system leavers)	29

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Number of adults who exited with increased non-employment cash income	15
Percentage of adults who increased non-employment cash income	51.7%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	29
Number of adults who exited with increased total income	18
Percentage of adults who increased total income	62.1%

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.	1,182
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.	446
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)	736

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.	1,390

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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.	471
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.)	919

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

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

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

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

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

Metric	Value

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MA-505 - New Bedford CoC

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

Universe: Persons who exit Street Outreach	133
Of persons above, those who exited to temporary & some institutional destinations	39
Of the persons above, those who exited to permanent housing destinations	76
% Successful exits	86.5%

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	1,756
Of the persons above, those who exited to permanent housing destinations	1,162

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% Successful exits	66.2%

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	293
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	289
% Successful exits/retention	98.6%

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

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

Unduplicated Persons Served (HMIS)	1,839	0	303	126	289
Total Leavers (HMIS)	1,637	0	31	95	108
Destination of Don’t Know, Refused, or Missing (HMIS)	134	0	0	0	3
Destination Error Rate (Calculated)	8.2%	0.0%	0.0%	0.0%	2.8%

2026 Competition Report - SPM Notes

MA-505 - New Bedford 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.

2026 Competition Report - HIC Summary

MA-505 - New Bedford 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[1] 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[1] 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	396	366	366	0	366	100.0%	30	30	0	30	100.00%	396	396	100.00%
SH	0	0	0	0	0	NA	0	0	0	0	NA	0	0	NA
TH	85	0	72	0	72	0.0%	13	13	0	13	100.00%	13	85	15.29%
RRH	1,639	0	1,639	0	1,639	0.0%	0	0	0	0	NA	0	1,639	0.00%
PSH	364	277	364	0	364	76.1%	0	0	0	0	NA	277	364	76.10%
OPH	69	28	69	0	69	40.6%	0	0	0	0	NA	28	69	40.58%
Total	**2,553**	**671**	**2,510**	**0**	**2,510**	**26.7%**	**43**	**43**	**0**	**43**	**100.00%**	**714**	**2,553**	**27.97%**

2026 Competition Report - HIC Summary

MA-505 - New Bedford CoC

For HIC conducted in January/February of 2026

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

3A-1
ATTACHMENT

HUD-2996 Certification for Opportunity Zone Preference Points

Although the majority of CoC Projects are, indeed located in Opportunity Zone Eligible Tracts, only a few are located within formally approved zones. As such, this attachment is not applicable.

3A-2a
ATTACHMENT

Project List for Other Federal Statutes

This attachment is not applicable.

3A-DP
ATTACHMENT

CoC's Policy to Advance Recovery

MA-505 CoC's Policy on Advancing Recovery and Ensuring Compliance with Federal Substance Use Regulations

1. Purpose and Scope

The Bristol County Continuum of Care (MA-505 CoC) is committed to fostering safe, "recovery-ready" housing environments that promote long-term self-sufficiency, wellness, and access to comprehensive behavioral health treatment. This policy applies to all housing and supportive service projects funded under the HUD Continuum of Care (CoC) program within our geographic jurisdiction. All sub-recipients executing HUD CoC grant agreements must operate in strict compliance with this policy.

2. Core Compliance Standards

To ensure adherence to Federal law and HUD's FY 2026 program mandates, all CoC-funded projects shall strictly maintain the following operational prohibitions:

- **Prohibition of Safe Consumption Sites:** No CoC-funded facility, housing unit, or programmatic site shall establish, operate, or permit the utilization of "safe consumption sites," supervised injection facilities, or any designated area intended for the unprescribed use of illicit substances.
- **Ban on Paraphernalia Distribution:** CoC funds—including administrative, operational, or supportive services line items—shall not be used for the acquisition, assembly, or widespread distribution of drug paraphernalia.
- **Prohibition of Illicit Drug Enablement:** CoC-funded programs shall not knowingly permit, foster, or enable the systematic or widespread use of illicit substances on taxpayer-funded properties. All projects must maintain operational guidelines that actively encourage compliance with Federal drug laws while prioritizing participant safety.

3. Preserving Local Flexibility and Participant Stability

While enforcing the prohibitions in Section 2, the CoC recognizes that sustainable recovery is a non-linear process. To prevent housing instability and unnecessary returns to homelessness, sub-recipients shall utilize a balanced, case-managed approach to compliance:

- **Individualized Intervention vs. Zero-Tolerance Evictions:** In alignment with HUD guidelines, a participant's struggle with substance use disorder shall not trigger automatic, immediate eviction or programmatic termination upon a single or first-time violation.
- **Progressive Treatment and Wraparound Services:** Sub-recipients are expected to respond to substance-related incidents with progressive engagement. This includes immediately offering

robust supportive services, behavioral healthcare, peer recovery coaching, and voluntary substance use disorder (SUD) treatment pathways.

- **Safety and Property Management:** Providers retain full authority to enforce standard lease agreements, property safety rules, and behavior clauses to protect the safety of all residents, staff, and the physical asset.

4. Monitoring, Enforcement, and Remedies

The CoC will monitor compliance with this policy during its annual project performance review and local evaluation processes.

- **Reporting:** If a sub-recipient identifies a systemic or operational violation of this policy within its projects, it must notify the CoC Board within 30 days and submit a voluntary Corrective Action Plan (CAP).
- **CoC Remedies:** If a project is found to be in non-compliance through a monitoring review or grievance investigation, the CoC reserves the right to implement localized remedies. These remedies are progressive and may include:
    1. Mandatory technical assistance and staff retraining.
    2. Implementation of a formal Corrective Action Plan.
    3. The restructuring or reallocating of project funds in future CoC competition cycles if non-compliance remains unresolved.

Adopted by a vote of the Executive Board

September 21.2026