

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: PA-506 - Reading/Berks County CoC

1A-2. Collaborative Applicant Name: Berks Coalition to End Homelessness, Inc

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Berks Coalition to End Homelessness, Inc

1B. Coordination and Engagement–Accountable Structure and Participation

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

- 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.	
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In the chart below for the period from June 1, 2025 to May 31, 2026:

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

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

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

17.	State Government Staff/Official(s)	Yes	2
18.	State or Local Elected Public Official(s)	Yes	4
19.	Local Jail(s)	No	
20.	Mental Health Service Organization(s)	Yes	0
21.	Mental Illness Advocate(s)	Yes	0
22.	Organization(s) led by and serving people with disabilities	Yes	0
23.	Other homeless subpopulation advocate(s)	Yes	1
24.	Other nonprofit homeless assistance provider(s)	Yes	2
25.	Other social service provider(s)	Yes	2
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	1
30.	Street Outreach Team(s)	Yes	1
31.	Substance Abuse Advocate(s)	Yes	0
32.	Substance Abuse Service Organization(s)	Yes	0
33.	Universities	No	
34.	Veteran Serving Organization(s)	Yes	1
35.	Agencies Serving Survivors of Human Trafficking	Yes	0
36.	Victim Service Provider(s)	Yes	0
37.	Domestic Violence Advocate(s)	Yes	0
38.	Other Victim Service Organization(s)	Yes	0
39.	State Domestic Violence Coalition	Yes	0
40.	State Sexual Assault Coalition	No	
41.	Youth Advocate(s)	Yes	1
42.	Youth Homeless Organization(s)	Yes	0
43.	Youth Service Provider(s)	Yes	0
44.	Other Homeless Assistance Provider(s)	Yes	2
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	1
	Other: (limit 50 characters)		
46.	Private Foundation	Yes	1
47.			

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

(limit 2,500 characters)

The CoC continually welcomes new members. CoC staff reach out to invite agencies not already included in the membership. Anyone can request to join the CoC by contacting CoC staff or filling out a form on the CoC's website. The transparent process includes:

1- A standing invitation with instructions and the membership forms are posted publicly on the CoC website throughout the year.

2 - The CoC advertises an invitation to join the CoC annually in October via email blast and website posting. The invitation email includes instructions on how to submit a membership form and includes a link to the membership form. The CoC lead agency contracted with a consultant during 2026 to create a targeted outreach strategy to bring new organizations into the CoC work. This includes working committees to implement the CoC's strategic plan, and during these meetings CoC membership information is shared and emphasized to organizations not already members.

Invitations to join the CoC, including the membership sign-up form, and all other CoC-related information (meeting info, CoC competition info, CoC updates, etc.) are supplied via PDF by email and on CoC website to ensure effective communication and ensure everyone is aware of how to join the CoC. The CoC's website provides features for those with visual impairments, and provides features to improve accessibility and to allow users to view the website in various languages.

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

(limit 2,500 characters)

A- The Berks County CoC maintains a transparent, multi-channel process to solicit, consider, and integrate community feedback into its performance evaluations, strategic priorities, and policy development. Opportunities for input are publicly posted on the CoC Lead Agency website and social media channels. The CoC holds open to the public, monthly general membership and Coordinated Entry (CE) meetings where performance data, annual PIT Count planning/results, and HUD NOFO priorities are presented and discussed; meeting minutes, resources, and feedback are systematically distributed via public email lists. Continuous opinions from current and formerly unhoused individuals are captured through dedicated bodies like the Lived Advisory Board (LEAP), Youth Action Board (YAB), and street outreach (SO) soliciting feedback from partnering agencies. In 2025, the CoC executed an extensive, publicly advertised strategic plan to establish priorities to prevent/end homelessness. This effort collected community-wide input through focus groups with people with lived experience, service providers, and SO staff; key stakeholder interviews; a community-wide survey generating over 60 responses; and two well-attended public CoC forums (May&Oct 2025). To apply collected feedback, the CoC established targeted committees made up of a multitude of individuals/agencies of all backgrounds; there are representatives from all partners indicated below. These ongoing committee meetings are continuous opportunities for community members to participate in the CoC's general performance, strategies, and priority setting process

B- Over 50 organizations actively participate in the CoC. Engaged partners include: education, veteran services, faith based organizations, law enforcement and courts, behavioral health providers, physical health providers, substance abuse treatment providers, workforce/employment development, local business leaders, affordable housing developers, state/local government, public works, homeless service providers, and people with lived experience of homelessness. The CoC Charter reserves seats on the CoC Board to ensure a broad array of opinions (e.g. CoC/ESG funded, PHA, law enforcement, and elected officials)

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

(limit 2,500 characters)

A- On June 23, 2026, the CoC distributed the FY 2026 new project RFP (included info on the CoC program, instructions, and the application) through multiple email listservs serving the CoC's social services community and posted it on the CoC website. The RFP explicitly welcomed applications from organizations that had not previously received CoC Program funding, including faith-based organizations. CoC staff also promoted the funding opportunity at CoC-wide meetings and widely advertised a webinar for prospective new applicants. The webinar recording was shared through the email listserv and explained the application process, reviewed HUD requirements, and addressed questions. In addition, CoC staff had encouraged agencies without prior CoC funding to serve on the CoC scoring and ranking committee so they could better understand the process and feel prepared to apply in the future. Applicants submitted proposals describing their projects, experience and addressing HUD threshold requirements by the local competition deadline of July 15, 2026. The CoC funding committee reviewed and scored all proposals and accepted each one based on its scoring and how the project fit within the CoC's Strategic Plan. Applicants were notified of their acceptance on July 28, 2026, and instructed to complete their final applications in e-snaps.

B- The CoC intentionally invites agencies, including faith-based organizations, to apply for CoC funding that have not in the past. Because of this intentional outreach, the majority of new projects received by the CoC in FY26 were from organizations that have not received CoC funding before (4 applications from 4 different organizations). One of the organizations that applied in FY 2026 had previously participated in the CoC scoring/ranking committee after encouragement from CoC staff.

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

(limit 2,500 characters)

Gap- The CoC is implementing its 2026–2030 Community-Wide Strategic Plan to Address Homelessness as the framework for reducing homelessness, including interventions in 42 U.S.C. 11386b(d). The plan was developed using data from HMIS and Coordinated Entry (CE), stakeholder interviews, provider focus groups, and input from people with lived experience. A significant gap identified through this process is the lack of coordinated housing navigation, case management, and supportive services. Stakeholders reported that navigating the system can be confusing and individuals experiencing homelessness report feeling “bounced around” between resources. This gap was reported across all populations, and there was not a specific subpopulation that is impacted more than others. One of the recommendations is to create dedicated system navigator positions for people assessed through CE. The strategy will be implemented across all populations.

Strategy- The CoC is addressing this gap by strengthening the CE-to-housing pathway and pursuing resources to expand system navigation. The CoC lead agency (also the CE lead) will create a system navigation position embedded in the CE system. The CoC lead created committees/workgroups to assign ownership of strategic-plan recommendations; one committee is overseeing the system navigation recommendations of the strategic plan. This committee has established short, medium, and long-term goals, and is monitoring implementation and outcomes. The strategy being implemented is designed to be effective across/for all populations.

Measurement - The CoC will measure progress through the following indicators: the number of households receiving navigation services, referrals resulting in engagement with housing or supportive services, exits to permanent housing, and reductions in the length of time households remain homeless.

Funding- The CoC lead agency is responding to this gap by applying for a CE expansion grant in the FY26 CoC competition; the grant will fund a staff position to do system navigation and short-term case management for people who are assessed by CE but not enrolled in a housing program yet.

Responsible entity- The CoC lead agency will report these performance measures back to the committee overseeing the system navigation recommendations of the strategic plan.

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?	100%

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

(limit 2,500 characters)

N/A - Not a rural CoC.

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

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

(limit 2,500 characters)

The CoC has strong relationships with the Council on Chemical Abuse (COCA) and Treatment Access and Services Center, Inc (TASC); both organizations provide low- to no-cost substance abuse services (including conducting drug and alcohol assessments and CRN evaluations, peer groups, drug testing, and drop in centers for those in recovery) and blended case management services to help clients find treatment & stay connected to outpatient care. TASC assesses individuals and connects them with appropriate levels of care. Local shelters have recovery coaches embedded in their programs to ensure people receive care where they are; Recovery Coaching Services, Inc. visits people in encampments to ensure everyone has access to recovery resources. Service Access Management, Inc and Berks Counseling Center (CCBHC) provide outpatient mental health treatment, medication management services, and wrap-around case management for people with mental health disorders, intellectual disabilities, or developmental disabilities. They're experts in navigating the healthcare system and connecting clients to support and providers with a range of appropriate levels of care. The local hospital's Street Medicine team is active with the CoC's street outreach and provides immediate crisis medical care and long-term medical case management in the CoC. The county's mental health crisis/suicide prevention organization is a CoC Coordinated Entry access point and provides crisis intervention and long term care.

The CoC street outreach team, including Street Medicine, makes direct referrals to Holcomb (mobile psychiatric&behavioral health provider) that provides direct case management to unhoused people, including people staying in their cars and encampments. The case management program determines the appropriate level of care needed. Services provided include intensive outpatient, medication management, recovery support, and referrals to other services as appropriate. The program brings services to people experiencing homelessness into the community, which removes barriers to accessing care.

Street medicine, Holcomb, and local mental health service provider organizations all participate in the committees working on the CoC's strategic plan. The CoC convenes these organizations to work on addressing the barriers to ensure mental health and recovery services are embedded throughout the system. These committees meet multiple times a month with measurable goals to implement the strategic plan

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 CoC partners w/ local recovery organizations to provide peer recovery support and navigation to individuals & families experiencing homelessness. The CoC's largest emergency shelters (Hope Rescue Mission & Opportunity House) have peer recovery specialists on-site daily from a local recovery coaching organization. These peer specialists regularly engage shelter residents, provide recovery coaching, help individuals identify appropriate treatment & recovery resources, & support connections to detox, treatment, recovery housing, & other services. Peer recovery support is also available thru New Journey Community Outreach (NJCO); NJCO is a local drop-in center with daily warm meal distribution that serves over 400 people each day w/a majority of the visitors being unsheltered. Peer support specialists regularly engage individuals at NJCO and help people who are living on the street identify recovery goals and connect to appropriate treatment & recovery services. The CoC partners w/Tower Health Street Medicine to connect individuals experiencing homelessness w/healthcare and addiction services directly through street outreach. Thru this partnership, people w/substance issues are connected to peer recovery specialists who link them to detox, substance use treatment, behavioral health services, and ongoing case management. This approach reduces barriers to care & provides individuals with a direct pathway to treatment and recovery services.

The CoC also incorporates lived experience into its Street Outreach response. Outreach staff w/ personal recovery experience are able to use their lived experience to build rapport w/ individuals actively using substances and encourage engagement with treatment, recovery, and housing resources. Outreach staff coordinate with peer specialists, behavioral health providers, hospitals, emergency responders, & recovery organizations as needed to facilitate warm handoffs and reduce barriers to accessing care. The CoC will continue strengthening these partnerships by increasing opportunities for peer specialists to engage individuals in shelters & unsheltered settings, improving communication & referral pathways between peer supports and CoC housing providers, and incorporating peer recovery perspectives into outreach & service planning. This approach recognizes that peer support is effective in building trust, reducing stigma, promoting treatment engagement, & helping individuals move from homelessness toward recovery & housing stability

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

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

(limit 2,500 characters)

The CoC promotes identification of mental health (MH) needs thru Coordinated Entry (CE). Healthcare providers, schools, street outreach (SO), & other community-based organizations meet at least monthly in CE meetings (often more as needed) for case conferencing. The CE assessment includes questions related to MH, safety & overall well-being, allowing providers to identify MH concerns & make referrals for further assessment & treatment. People experiencing Serious Mental Illness (SMI) are connected to a continuum of MH services based on their needs. These services include individual & family counseling, psychiatric evaluation, medication management, case management (CM), intensive community-based services, peer counseling & other MH supports. CoC lead agency & CoC providers work w/ community MH providers to connect people to outpatient services, behavioral health treatment, care coordination & other supports that promote stability & community integration. SO team, including Street Medicine, make direct referrals to Holcomb Behavioral Health (provides CM to unhoused people). Services include intensive outpatient, medication management, recovery support, & referrals to other services. The program brings services to unhoused people where they are, removing barriers to care. Referrals are made by SO, CE & CoC providers to Haven Behavioral Hospital for assessment & treatment of SMI. Following crisis or inpatient treatment, providers & community partners assist people w/ transitioning back to community-based services & connecting them w/ ongoing treatment, CM, housing resources & other supports, including the ACT team. Tower Health's Assertive Community Treatment (ACT) program provides intensive, community-based support that helps individuals w/ severe & persistent behavioral health needs maintain stability outside institutional settings. Thru CM, medication support, therapy, substance-use counseling, healthcare coordination, & employment/education assistance, ACT strengthens housing stability & ongoing community integration. People w/ SMI access emergency services thru the county crisis center, mobile crisis response & emergency departments. Crisis workers on the CoC's SO team are able to respond quickly to assist unhoused people experiencing a crisis. Thru these partnerships, the CoC ensures that people w/ SMI are identified early, connected to appropriate care & supported w/ ongoing services to promote stability, housing retention, recovery & community integration.

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 Lead has a seat on the Treatment Court Advisory Board for the CoC geographic area, and partners with the Council on Chemical Abuse (COCA) to strengthen pathways to housing stability and recovery for individuals involved in specialty courts. COCA supports the Specialty Court Recovery House case management program, connecting treatment court participants to recovery housing, level-of-care assessments, intensive case management, and recovery support services.

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

(limit 2,500 characters)

The CoC coordinates with the Council on Chemical Abuse (COCA) to support housing stability and movement toward independence for individuals involved in specialty courts. COCA operates the Specialty Court Recovery House (SRO) program, funded through a partnership with the YMCA of Reading, providing intensive case management, recovery support, and level-of-care assessments for treatment court participants.

The CoC Lead has a seat on the Treatment Court Advisory Board, facilitating direct communication between CoC leadership, COCA, YMCA and court personnel. This position enables real-time information sharing about housing availability, eligibility criteria, and individual client progress.

The YMCA SRO project, on behalf of COCA, utilizes the CoC's Coordinated Entry (CE) system to streamline housing placement. When treatment court participants complete initial stabilization phases, YMCA case managers submit referrals to the CoC's CE process. This ensures individuals are appropriately assessed and prioritized based on vulnerability and housing needs. The CE system allows the YMCA to access the full inventory of CoC-funded housing resources, including emergency shelter, transitional housing, and permanent supportive housing units.

Court orders serve as a critical leverage point in this coordination. Specialty courts frequently mandate housing participation as a condition of program completion. YMCA case managers work with court officers to ensure treatment court participants understand housing requirements and receive support meeting these mandates. When court orders specify housing stability as a condition, YMCA and COCA coordinate with CoC housing providers to secure appropriate placements, documenting compliance for court reporting purposes. The CoC and COCA also collaborate on data sharing and outcome tracking. This collaborative approach allows for continuous program improvement and ensures housing interventions align with treatment court goals and individual recovery plans.

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

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

(limit 500 characters)

The CoC partners w/Holcomb (local crisis response org) Haven Behavioral Health&Tower Health Street Medicine to connect individuals experiencing behavioral health or substance use crises to stabilization&treatment. Holcomb specializes in providing mobile crisis&outreach services, as well as crisis stabilization services. CoC street outreach identifies individuals in crisis, coordinates w/ Street Medicine&behavioral health partners&facilitates connections to appropriate stabilization services

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.	67

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)

Berks Counseling Center (BCC) Certified Community Behavioral Health Clinic (CCBHC), is a formal CoC member, partner & CoC-funded housing provider w/in the CoC. BCC provides integrated mental health, substance use disorder, case management, peer support & physical health services in addition to their housing programs. CoC providers coordinate referrals w/ BCC to connect people experiencing homelessness to behavioral health & recovery services while supporting housing stability and retention

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)

Easy Does It operates CoC-funded permanent supportive housing in the CoC, offering recovery housing in alignment w/24 CFR 578.93(b)(5). Chronically homeless people w/substance use disorders are provided a safe, alcohol/drug free housing w/ daily structure, peer accountability&personalized case management. Thru certified recovery support specialists, residents are connected to outpatient treatment, life skills training, employment opportunities&permanent housing solutions across Berks County

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

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

(limit 2,500 characters)

The CoC coordinates behavioral health, substance use, crisis, peer recovery, healthcare, specialty court, and housing partners to facilitate warm hand-offs & prevent individuals from entering or returning to homelessness. CE, SO, shelters, treatment providers, healthcare partners, & housing providers communicate, both on the scene of a crisis and during monthly CoC & CE meetings, to identify housing needs and connect individuals to appropriate resources. COCA manages a Warm Handoff Program that covers the entire geographic area of the CoC. This program works to provide treatment intervention to individuals who enter hospitals with substance use disorders. Once a patient is medically stable, they meet with a Certified Recovery Specialist (CRS) who provides support and guidance for accessing treatment. The CRS is employed by a substance abuse provider, TASC, & is credentialed by the Pennsylvania Certification Board. The program is also accessible by walking into the local hospital's emergency room; the hospital connected more than 700 individuals to recovery resources in 2025.

The largest food distribution drop-in center, NJCO, sees a majority of the unsheltered population throughout the week; NJCO has peer recovery specialists on staff & will make warm handoffs to recovery services, including inpatient and detox centers. The CoC's street outreach and Tower Health Street Medicine build on this approach by directly engaging unsheltered individuals & connecting them to detox, substance use treatment, behavioral health services, crisis stabilization, & ongoing case management; recovery partners and other community providers participate in outreach efforts when available. These partnerships allow individuals to receive direct assistance and referrals instead of being given information to navigate services on their own. CoC providers, including BCC (local CCBHC), EDI (CoC-funded recovery housing), SAM, COCA, TASC, crisis response partners (Holcomb and Haven), and peer recovery specialists, coordinate with CE and housing providers to support transitions from treatment and recovery services into shelter and housing. These organizations assist with applications, documentation, benefits, transportation, treatment connections, and other barriers that could prevent successful housing placement. The various case management programs connect participants with assessments, treatment, and ongoing recovery support while coordinating with CE and CoC housing resources.

1C-2.	Supportive Services Investment.	
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	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$5,938,975
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.	\$2,684,122
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	45%
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.	\$1,005,065
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).	62%

1C-3.	Participation Requirements for Supportive Services.	
	You must upload the Language from Project Supportive Service Agreements attachment to the 4A. Attachments Screen.	
	What percent of your housing projects (TH, PH-PSH, PH-RRH, and Joint projects) require program participants to take part in supportive services (e.g. case management, employment training, substance use disorder treatment) in line with 24 CFR 578.75(h)?	100.00%

1C-4. Consulting with ESG Recipients.

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

(limit 2,500 characters)

Both Berks County and City of Reading are ESG recipients, and are the only ESG recipients in the CoC's geographic area. The CoC works closely with both participating jurisdictions (PJs) in planning and allocating ESG funds. Every year both entities request the CoC's recommendations and meetings are held to discuss how to best utilize the funds to fulfill the needs of our community. The CoC also assists PJs in distributing the request for applications to the community.

The CoC supports the City of Reading and Berks County ESG recipients/subrecipients with HMIS data and compliance. Monthly data quality reviews are conducted on every project in HMIS, including ESG projects and intentional support is provided to projects struggling with data quality. The CoC monitors projects through project performance measures and system performance measures. Coordinated Entry monitors ESG project compliance with policies and procedures during case conferencing meetings and follow ups between meetings.

The CoC shared PIC and HIC data with both the City of Reading and Berks County in Feb 2026 so that their strategic priorities for addressing the local needs of the CoC's unique homeless population are considered while developing their Consolidated Plan and making funding decisions. The offices responsible for these plans both communicate often with our CoC and are active participants in the CoC's strategic plan implementation. Currently the CoC lead agency and both City and County PJs are working together to create a policy for severe weather programming. There have been monthly meetings since November 2025 to work on policies, procedures, and an RFP. ESG funds will be used to support any severe weather programming that is attached to this policy. Representatives from the PJs participate in funding committees for various funding sources, including the severe weather programming funded with ESG. This newly created funding committee ensures ESG funds are allocated strategically. The severe weather policy and the funding committee were recommendations from the Strategic Plan.

The CoC lead agency staff attended the City ESG, HOME, and CDBG needs hearing in May 2026. During the meeting, the CoC staff presented to the ESG recipient about the current state of homelessness, shared recommendations from the CoC's strategic plan, and provided priority areas/projects to be funded.

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)

All four main shelters within the CoC are trained annually to serve as Coordinated Entry (CE) access points and participate in monthly CE meetings, including the one non-HMIS participating shelter in the CoC. The CoC facilitates ongoing coordination between shelter providers, CE, street outreach, and local agencies through monthly coordinated entry meetings to discuss client progress, identify barriers, and coordinate referrals to housing and supportive services.

CoC staff and CE partners use these coordinated efforts to maintain awareness of households engaged in the CE system and to support shelter providers in moving participants toward permanent housing. Shelter staff actively connect residents to housing opportunities and complete referrals, while CE and CoC partners provide additional coordination and support. The CoC's SOAR staff go into the shelters to work directly with shelter residents to assist eligible individuals with accessing SSI/SSDI benefits, when appropriate.

The CoC has a Housing Navigator to connect individuals and families to CoC assistance. This position works daily with the shelters and CE to connect CoC participants with units in the community that best fit their needs.

The Street Outreach team acts as an extension of CE and visits the shelters weekly. They check in with shelter residents to ensure CE has the most up-to-date information about the households. This ensures that coordination of care happens quickly when there is CoC assistance available.

To further strengthen local capacity, the CoC offers dedicated training to shelter staff on system workflows, best practices, and program access. Additionally, shelter staff attend monthly CoC meetings, allowing them to stay informed on emerging community resources, build cross-agency partnerships, and better connect residents to local support networks.

The CoC is engaged in strategic planning to improve the coordination between shelters and CoC housing assistance; one CoC committee is tasked with working on navigation of the system and removing barriers to accessing assistance. The work of this committee includes improving access to CoC assistance for people in shelter.

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

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

(limit 2,500 characters)

The CoC regularly shares homelessness system data with state and local government partners to inform planning, policy, and resource allocation. On the CoC's website, there is a public webpage that includes aggregate PIT, HIC, System Performance, and CoC Performance reports, providing community stakeholders with access to current and historical information on homelessness trends and system outcomes. The CoC also shares aggregate data and findings throughout the year with state legislators, members of Congress, and local government officials. These communications provide decision-makers with information about the scope and characteristics of homelessness, available housing resources, system performance, and emerging community needs. The CoC lead agency hosts an annual public "State of Homelessness" to share key findings with the community to help inform local strategies and priorities. This provides an opportunity to review trends, discuss system performance, and identify areas requiring additional resources or coordination. In February 2026, the CoC released the Community Wide Strategic Plan, which included an in-depth data analysis of needs and gaps; this plan used the PIT, HIC, and SPM data to inform the gaps analysis. Multiple state and local officials and leaders were in attendance for the presentation. The CoC has a data sharing agreement with the PA Department of Education to share client-level data about school-aged children; the Dep of Ed uses this to create reports on the number of students experiencing homelessness each school year. The CoC has a data sharing agreement with Berks County to share client-level data for their "Stepping Up" group that analyzes data from HMIS, the jail system, and the behavioral health system; this group specifically targets people with severe mental illness and identifies trends with recidivism rates and connections to care after exiting the jail system. Data is shared in accordance with applicable laws, regulations, and HMIS policies. Through regular reporting, direct communication with government partners, and annual public presentations, the CoC uses PIT, HIC, HMIS, and System Performance data to support informed decision-making and continuous improvement of the local homelessness response system.

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

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

(limit 2,500 characters)

The CoC is receiving technical assistance from a consulting firm on a system-level data sharing project. The project began in May 2026 and is in its first phase of a multi-year endeavor. The first phase of the project is scheduled to be completed by April 2027. The working group for the project consists of representatives from the CoC's jail, probation and parole agencies, behavioral health organizations, the county government, Medicaid providers, and homeless service providers; the CoC lead agency is organizing this work group. The work group is in the process of creating data sharing agreements between HMIS, the health care and jail system, and other relevant data systems to improve care. The initiative, called "Frequently Used Systems Engagement" (FUSE), is intended to increase data sharing and collaboration between all systems to find people who cycle through the systems frequently. Once these most frequent users are identified, a workgroup of providers from these systems will work together to create interventions designed to target this specific population. In addition, the County mental health department runs a "Stepping Up" group to combine jail system data, healthcare and behavioral health data, and HMIS data to identify patterns. This group specifically targets people with severe mental illness and identifies trends with recidivism rates and connections to care after exiting the jail system. The CoC lead agency is an active participant of the Stepping Up group. The CoC has a Youth Homeless System Improvement Grant to create a system map of the youth homeless response system across the CoC and two neighboring CoCs. Part of this mapping activity is conducting listening sessions with youth to gather data on their experiences within the system. The CoC will use this qualitative data alongside HMIS data to identify gaps in the system and make recommendations to fill those gaps and improve care.

1C-6. Employment and Workforce Development Partnership.

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

(limit 2,500 characters)

The CoC partners w/ Connections Work (reentry employment assistance), PA CareerLink (State Workforce Agency) & both organizations are active CoC members. The CoC has formal partnerships w/ educational institutions, vocational training providers, apprenticeship programs&local employers to connect individuals experiencing homelessness w/ career exploration, job readiness, and employment opportunities. These partnerships support pathways to employment &increased long-term housing stability

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

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

(limit 2,500 characters)

The CoC collaborates with first responders, public systems, and community partners to connect individuals experiencing homelessness to housing and supportive services. CoC staff and SO operate as a point of contact for personnel on the scene of a crisis involving an unhoused person. CoC staff and SO deploy to the scene to coordinate responses among EMS, law enforcement, healthcare, businesses, behavioral health, schools, child welfare, CoC street outreach, and homeless service providers. When encountering individuals in crisis, collaborating partners consult with SO and CoC staff to engage CoC coordinated services. This allows CoC staff and SO to assess available CoC capacity, coordinate immediate supportive services, and stabilize individuals on site; rather than diverting toward unnecessary use of public safety, emergency healthcare, and related public funding costs.

A key partnership exists between the CoC and the Reading Police Department. Police and Public Safety notify the CoC's street outreach team prior to every encampment sweep, allowing outreach staff to visit encampments several times prior to a sweep to address service barriers and coordinate referrals to shelter, supportive services, and housing. If police department social workers are on patrol or a crisis call and encounter an unhoused person, they call in and work with SO to make connections and referrals. Outreach teams deploy directly to the scene to provide immediate, trauma-informed support, maintaining public safety while prioritizing long-term housing.

The local mental health crisis agency and Street Medicine team attend monthly CE case conferencing and conduct CE assessments. First responders and crisis workers join outreach efforts to engage unsheltered youth, which recent data collected through the YHSI grant suggests is an increasingly vulnerable population. When unsheltered youth are encountered, CoC staff, SO, and partnering professionals direct them to designated 'Safe Place' access points like Mary's Shelter (a CoC partner) and the Reading Public Library for immediate aid and supportive services. Beyond emergency crisis intervention, these partners connect youth to CE prioritization and housing navigation. This multi-agency safety net ensures unsheltered youth bypass long-term homelessness and transition rapidly into stable housing.

1C-8. Family or Support Network Reunification.

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

(limit 2,500 characters)

Coordinated Entry, street outreach, and shelter staff are all trained annually in diversion techniques, including reunification w/family or support networks . Through Coordinated Entry and outreach services, providers work with participants to identify family members, friends, or other supportive networks that may offer a safe and sustainable housing or support option. Providers work with participants to consider all possible resources in an effort to find creative, safe, and cost-effective solutions to end their homelessness.

A key component of this diversion work is the CoC's Ticket Home program. Ticket Home is designed to help individuals and households experiencing homelessness reconnect with family or supportive networks outside of the CoC when returning to that community is safe, desired, and likely to support long-term stability. The program purchases and coordinates transportation to help the person travel to a place outside of the CoC where they have a safe and permanent place to stay and a stronger support system, thus ending their homelessness.

The CoC's largest youth shelter works to intervene with youth experiencing housing instability early to help them avoid homelessness. If youth do become homeless, the shelter prioritizes family reunification using family reunification services such as Diakon or the Public Child Welfare Agency, when safe and appropriate.

The CoC recognizes that reunification is not appropriate in every circumstance, particularly for individuals or households fleeing domestic violence, abuse, neglect, trafficking, exploitation, or other unsafe situations. In these cases, providers prioritize safety and assist participants in developing other permanent connections and supportive relationships while pursuing stable housing, long-term stability, and self-sufficiency.

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

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

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

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

(limit 2,500 characters)

The CoC&the CoC's street outreach (SO) team never interfere/impede efforts to advance protecting public safety. Rather, the CoC supports coordinated responses among emergency medical services, law enforcement, healthcare providers, behavioral health agencies, juvenile&adult justice systems, SO teams, victim service organizations,&homeless service providers to identify people in crisis&facilitate timely connections to CE&other appropriate resources. The CoC supports cross-system collaboration thru established partnerships, regular case conferencing, information sharing,&coordinated service planning

Police&Public Works notify the SO team prior to every encampment sweep, allowing SO to visit encampments several times prior to a sweep to address service barriers&coordinate referrals to shelter, supportive services,&housing. If police social workers are on patrol or a crisis call&encounter an unhoused person, they call in&work with SO to make connections&referrals. SO deploys directly to the scene to provide immediate, trauma-informed support, maintaining public safety while prioritizing long-term housing.

SO staff actively support decreasing public use of drugs by connecting people to recovery supports, including peer supports, recovery specialists, warm handoff programs,&inpatient treatment.

CoC providers&SO coordinates w/law enforcement to share info in accordance w/ SORNA. Including:

- Regular communication w/ probation&parole
- Immediate reporting of registration non-compliance to authorities within the bounds of the law
- Shared monitoring plans for high-risk people

The CoC assists first responders in providing services to people experiencing homelessness by: -First responders in the CoC have a direct line to the CoC's SO team, and regularly call for assistance.

-The local mental health crisis agency&Street Medicine team participate in monthly CE case conferencing meetings and are trained to conduct CE assessments; this connects people living outside with resources and medical care, thus reducing the number of calls first responders receive. CoC SO, Street Medicine, and public safety professionals work together to divert individuals who present as a risk to self or others to Holcomb Behavioral Health (local delegate responsible for psychiatric emergencies, evaluating danger risks, & initiating involuntary holds).

-First responders&community partners participate in SO efforts to engage unhoused people&connect them to housing&supportive services

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)

A practice that helps the CoC's ability to quickly clear tents and encampments on public property is a local law declaring camping as prohibited in public places, as stated in chapter § 396-305. Understanding this law is pertinent to maintain order & conduct within the CoC's geographic area, the CoC works to connect individuals who are camping in public to appropriate supportive services; this is possible due to a robust relationship between CoC staff, street outreach, public safety, and local law enforcement. The CoC lead agency coordinates & hosts a biweekly "crisis response team" meeting where homeless service providers, street outreach, local government officials, public works, & law enforcement come together to address encampments on public property. In between crisis response team meetings, the City's Public Works Department, as well as the local police department, notify the CoC street outreach team immediately when encampments are identified, allowing for rapid engagement & resource connection. Street outreach staff visit the encampments daily throughout the week to engage individuals, offer resources, and do coordinated entry assessments. Prior to campsite sweeps, street outreach staff work with people living in the encampment to store their vital documents and medications, and make plans for where to move to next in an effort to connect these individuals to appropriate services. The CoC worked w/ local government and law enforcement to develop the "Ticket Home" program to reconnect unsheltered people with family or supportive networks when appropriate. The CoC will continue to leverage this practice of strong communication between the City and law enforcement and street outreach to quickly clear encampments.

Challenges to quickly clearing encampments include limited housing options (as seen in City of Reading's 2024-2028 Equity Plan suggesting 5000 additional housing units are necessary to meet the needs of 75% low/moderate income residents), transportation barriers, shelter capacity constraints (as described by local shelters having to decline due to capacity), and reluctance among people to engage with formal systems. The CoC's plan to address these barriers is to continue strengthening outreach coordination, referral pathways&partnerships while monitoring unsheltered homelessness through PIT Count data, outreach contacts, and Coordinated Entry assessments. The CoC is continually advocating to local government for more affordable housing

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)

Unsheltered homelessness in the CoC is concentrated in small, dispersed encampments of 5-10 individuals located along wooded areas, underpasses, and other secluded locations rather than large, established tent communities. Street Outreach describes the number as less than 10 established encampments, with one exception being a single, large encampment by the Schuylkill River consisting of approximately 40 people. Encampment dynamics vary significantly by season. Occupancy and visibility peak during spring and summer, when emergency shelter capacity is constrained. The street outreach team reports that during the spring and summer seasons outreach workers are unable to get people from the encampments into shelter due to lack of available beds. In winter, Code Blue funding expands shelters' bed capacity, temporarily reducing the unsheltered and encampment population. These encampments are mainly concentrated in the largest city in the CoC, however there are sometimes smaller groups of one or two people dispersed throughout the CoC's more suburban/rural areas. Encampments are often temporary, with individuals relocating frequently due to weather, safety concerns, or changing circumstances. Local authorities clear tents monthly on an as needed basis. Clearing encampments does not eliminate unsheltered homelessness; instead, it temporarily fractures encampments and disperses individuals to other locations before reestablishing nearby within 1-2 weeks. Understanding this, the CoC, law enforcement, local municipalities, first responders, and outreach providers coordinate to identify encampments and engage individuals experiencing unsheltered homelessness to refer them toward housing and supportive services.

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)

The CoC recognizes that public use of illicit drugs is a public-safety concern & an opportunity to connect unhoused people to treatment, recovery, mental health, & housing services. Pennsylvania law prohibits possession & use of controlled substances, while local enforcement tools address public consumption & nuisance activity. The CoC's largest city has a marijuana ordinance establishing civil penalties for small amounts of marijuana & includes a diversion pathway, while public smoking or consumption remains prohibited. These policies provide opportunities to address public drug use w/o relying only on criminal enforcement. The community has established practices that support diversion, treatment, & accountability. In the CoC, there are treatment courts that combine judicial supervision, drug testing, treatment, case management, & recovery supports to promote public safety & reduce recidivism. The County has a pretrial diversion program for people w/ limited/no prior criminal record; this program provides assessment & treatment referrals for people involved w/ illegal substances. In the CoC, there is a Warm Handoff system that provides 24/7 intervention & connections to detox, residential treatment, & outpatient services for people presenting w/ substance-use concerns; the program is accessible by walking into the hospital's emergency room; the hospital connected 700+ people to recovery resources in 2025. The CoC's plan to leverage these beneficial policies includes strengthening coordination among CoC outreach teams, Reading Police, EMS, hospitals, TASC, behavioral health providers, treatment courts, & other recovery partners. SO staff engage individuals observed using substances in public, assess immediate safety & service needs, provide referrals, & use warm handoffs to facilitate rapid connection to treatment & other support. When public drug use involves immediate threats to safety, criminal activity, or other circumstances requiring enforcement, the SO team coordinates w/ police while maintaining appropriate confidentiality and trauma-informed practices. The CoC emphasizes diversion, service connection, & housing stabilization whenever legally appropriate. The CoC monitors barriers & recurring locations through coordinated outreach & communication w/ partners, identifies gaps in treatment or recovery access, & uses this information to improve referral pathways. Leveraging these beneficial policies has resulted in a 6% decrease in opioid-related arrests from 2024-2025.

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)

In the PA-506 CoC geographic area, substance use disorder remains a persistent public health challenge that directly intersects with public safety and housing stability. According to the Pennsylvania Department of Health, the CoC's county maintains an overall drug overdose mortality rate of approximately 25 deaths per 100,000 residents. Although this figure captures incidents across private and public settings countywide, public drug use and non-fatal overdose crises most significantly impact local parks, downtown corridors, wooded encampments, under bridges, near railroad tracks, and in more secluded areas across Reading (CoC's major city) and Berks County. To mitigate public displays of substance use and prevent fatal overdoses in shared community spaces, the CoC relies on an integrated, street-level intervention network that collaborates across healthcare, housing, and outreach systems. The Street Medicine team works directly with the CoC street outreach team to identify and engage individuals showing signs of active drug use or heightened overdose risk directly in community spaces. Central to this effort is establishing a direct pipeline from public encounters to long-term recovery, managed through agencies like Council on Chemical Abuse (COCA) and Treatment Access and Service Center (TASC). Between 7/1/24 and 7/1/25, TASC provided 2,243 client interventions where staff connected individuals to vital outpatient care, and residential treatment. Within that same FY24-25 timeframe, TASC facilitated 757 warm handoff interventions related to illicit drug use; these interventions include direct, peer-to-peer connections to recovery specialists and outpatient care. TASC uses Certified Recovery Specialists for peer to peer warm handoffs. Leveraging these beneficial practices has resulted in a 6% decrease in opioid-related arrests from 2024 to 2025.

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)

Involuntary commitment in Berks County is driven by state law (PA Mental Health Procedures Act (MHPA). Per the law, unhoused persons presenting an imminent risk to themselves/others can legally be involuntarily committed as needed. CoC SO, emergency services&public safety work together to divert people who present as a risk to self/others to Holcomb (local org responsible for psych emergencies, evaluating danger risks&initiating involuntary holds)

The CoC sees several barriers to sustained intervention. MHPA sets a specific statutory threshold for involuntary intervention ex: requires a person meet the “clear&present danger” standard. A person may have significant behavioral health(BH) needs/recurring unsafe behaviors but not meet the legal criteria for involuntary commitment at the time of assessment. MHPA does not allow involuntary commitment solely for substance use or intoxication w/o a qualifying mental health condition. Administrative requirements&coordination among SO, crisis services, law enforcement, emergency room, etc. can further delay/complicate response, especially when providers have limited access to a persons history

Harmful practice: involuntary commitment doesn’t guarantee stabilization. After emergency eval, a medical professional may determine involuntary treatment is not needed. For unhoused people, discharge results in return to homelessness w/o: stable housing, ongoing treatment, transportation, or other support; which increases risk of recurring crises

Despite these barriers, involuntary commitments decreased by 22% while voluntary commitments increased in the same timeframe; this is due to people getting access to MH services before their situations deteriorate needing commitment, which is beneficial to the CoC’s efforts

The CoC plans to mitigate these barriers by ensuring CoC funded providers understand local crises&involuntary commitment procedures &maintain clear protocols for contacting Crisis Intervention Services when safety concerns arise. It is expected that providers will document observable behaviors, threats, attempts, injuries&other info to support timely risk assessment. When individuals do not meet involuntary-treatment criteria, CoC agency providers&staff will be directed to voluntary crisis services, BH, substance use treatment, case management&housing supports. The CoC will continue to work w/partnering agencies to establish housing/shelter, transport, treatment&follow up support prior to discharge

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

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

(limit 2,500 characters)

The CoC and its provider networks adhere to federal and state Sex Offender Registration and Notification Act (SORNA) standards under Pennsylvania's Megan's Law. Local implementation presents both beneficial practices and restrictive barriers that shape how the CoC manages public safety and housing access. A beneficial practice was established in 2024 when the CoC formalized direct membership with local Adult Probation and Parole offices. This partnership established direct communication channels that facilitate secure, compliant information sharing regarding registered individuals experiencing housing instability. Local emergency shelter screening policies and private housing proximity rules like strict buffers around schools and daycares or caps on registered residents in congregate settings sometimes hinder housing placement. These restrictive practices often push unhoused registrants into unsheltered accommodations, making the mandatory monthly location reporting required for transient individuals under state law difficult to maintain. To leverage beneficial partnerships while mitigating these restrictive barriers, the CoC executes a comprehensive plan. First, CoC staff maintain cross-system coordination with probation and parole officers, utilizing CE and SO to track location changes and ensure unhoused clients remain in full compliance with state registration mandates. Second, the CoC collaborates with specialized behavioral health providers to offer clinical assessments, trauma-informed care, and alternative housing navigation for individuals excluded from traditional shelters. This strategy is supported by both quantitative and qualitative evidence. Quantitatively, 100% of CoC-funded housing projects verify background checks during intake. Qualitatively, street outreach workers and probation officers report that eliminating information silos enables teams to quickly locate unsheltered registrants, assist with transient updates, and prevent clients from incurring parole violations or returning to custody while actively seeking housing.

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)

Street Outreach(SO) is coordinated by the CoC lead agency&consists of volunteers from other partners (law enforcement, crisis response, street medicine, etc.). SO maintains relationships w/unsheltered people&frequently visits them to broker services. SO team members speak Spanish&have access to other translation services as needed to ensure people w/ limited English proficiency can access services. SO policies say if a referral is made or SO learns of an unsheltered person, they engage with them w/in 1 business day. If a person initially declines services, SO will continue to engage&offer services. SO efforts are targeted to encampments, parks, day centers, meal programs,&libraries to ensure all unsheltered persons are identified&engaged. The SO team has connections w/ libraries, police depts, churches&other social service organizations in rural parts of the CoC&responds to calls from these partners w/in 1 business day. SO provides the same level of engagement to rural areas as they do in the urban areas w/regular checks, providing supplies,&connecting people to resources including transport to programs/shelters. 290 unsheltered people were connected w/Coordinated Entry (CE) in 2025. The SO team regularly reevaluates their schedule to ensure SO efforts are still effective&the team gathers feedback from other providers&people w/lived experience on locations to reach people who are least likely to request assistance. One population that is difficult to connect w/are people living in their cars. They were not likely to request assistance b/c they don't want emergency shelter&don't know there are other resources available. In response to this growing trend, the CoC created a Safe Parking Lot as a place where people can more safely sleep in their cars and SO can build a relationship w/ them to quickly rehouse them. When someone parks at the lot, SO goes the next morning to make contact, offer services, provide supplies&enter them into CE. Street Medicine (SM) is a team of volunteer doctors & nurses that provide medical care to unhoused people. SM is a vital part of the SO efforts&holds medical clinics in the community&shelters weekly. They frequently go out to encampments to check on people who are hesitant to visit service locations/clinics. SM has a strong rapport w/ the unhoused community&are often the only trusted contact for people who are least likely to seek assistance. SM shares info about unsheltered contacts w/the CoC w/in the confines of HIPAA

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

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

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

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

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

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

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

(limit 2,500 characters)

The CoC's formal written policies and procedures regarding educational eligibility are established and published within the PA-506 CoC Written Standards. According to these written policies, all CoC-funded projects are required to maintain internal written protocols ensuring every individual and family experiencing homelessness is explicitly informed of their educational rights under the McKinney-Vento Act and connected to available educational resources. Procedures for Informing Individuals and Families include:

- 1- Intake and Assessment Review. CoC agencies are required by written policy to inform families and youth of their educational rights upon admission during the initial intake process. Staff review these rights verbally, distribute written educational rights notices, and revisit eligibility as needed throughout enrollment.
- 2- Designated Staff Point Persons. Each CoC organization must designate at least one staff member as the formal Educational Liaison point person. This individual is responsible for ensuring clients are informed of their rights, facilitating school enrollment, and coordinating with Local Education Agency (LEA) McKinney-Vento liaisons and the Pennsylvania Education for Children and Youth Experiencing Homelessness (ECYEH) program.
- 3- Outreach and Direct Engagement. ECYEH staff and ECYEH Outreach Specialists conduct direct, face-to-face meetings with unhoused families at shelters, CoC agency sites, and community resource fairs to explain educational rights directly to parents and youth and assist with enrollment. The CoC verifies adherence to these written standards through an annual project monitoring process. To ensure agency staff remain equipped to inform clients accurately, mandatory training on McKinney-Vento educational rights occurs annually during CoC-wide meetings, including specialized training presented by Pennsylvania ECYEH staff in September 2026.

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

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

(limit 2,500 characters)

The CoC coordinates with child welfare agencies, foster care providers, school districts, behavioral health providers, and youth-serving organizations to support youth transitioning from public systems of care who are at risk of or experiencing homelessness. Through Coordinated Entry, youth at risk of homelessness while transitioning from public systems of care are connected to appropriate housing interventions, case management, and mainstream resources based on individual needs and circumstances. The CoC works with child welfare and youth-serving partners to identify housing and service needs before system exit, facilitates referrals, and reduces the risk of youth entering homelessness.

The CoC lead agency continually works to expand options for youth transitioning from systems of care. For example, the CoC met with the local PHA and public child welfare agency on August 18, 2026 to begin creating a Foster Youth to Independence (FYI) voucher program in the CoC; all three parties recognize this is an unused resource in the community and would address a significant gap in the system.

Providers in the CoC coordinate with child welfare professionals, caregivers, schools, behavioral health providers, and education and employment partners, including post-secondary education, job training, and other specialized youth programs. Youth are connected to education, employment, life-skills development, behavioral health services, benefits, and permanent housing resources. Youth with lived experience of foster care involvement are helping inform this planning. Their perspectives can reveal barriers that are easy to miss in an agency-designed process, such as confusing eligibility information, difficulty reaching the right person, delays between referral and assistance, or a lack of support when searching for a unit. The CoC is using this input to shape its processes and partnerships so that youth have a clearer path to assistance and a voice in decisions affecting them. This planning also complements the CoC's broader current YHSI work. Youth input and system mapping help identify where connections among child welfare, housing, and other services need improvement. As the FYI pathway develops, the CoC intends to use those findings to strengthen transition planning and reduce the risk of homelessness when young people leave foster care.

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 CoC does not have any U.S. Department of Health and Human Services (HHS) RHY-funded programs in the geographic area.

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)

Opportunity House's STEP (Supporting Transitions through Empowerment and Progression) program is a HUD-funded Transitional Housing project serving families experiencing homelessness in Berks County. STEP provides housing and intensive supportive services to parents with at least one child, with the goal of helping families transition to permanent housing and stability.

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)

Opportunity House's STEP program utilizes tailored case management and strategic community integration to deliver supportive services focused on increasing family income and ensuring long-term rent sustainability. Recognizing that stable employment is vital for housing retention, case managers conduct individualized assessments to identify participant's work history, educational attainment, skill set, and personal goals. Based on this assessment, customized action plans are created to target career advancement and wage growth. Central to this effort is direct collaboration with local workforce development agencies. Case managers actively partner with PA CareerLink to connect participants with registered apprenticeship programs, industry-recognized certification courses, vocational training, and comprehensive job search services. Through partnerships with agencies like Connections Work (reentry employment organization) and regional employment specialists, participants gain access to targeted workforce readiness programs, local job fairs, and direct employer placements aligned with their capabilities and career paths. Case managers provide hands-on coaching to eliminate common employment barriers, which includes assisting with resumes, online job applications, interview techniques, and obtaining critical documentation like state IDs, birth certificates, and background clearances. To ensure consistent job attendance and retention, case managers assist families in overcoming logistical hurdles like transportation barriers and leveraging Opportunity House's on-site Keystone STARS rated learning centers for flexible, non-traditional childcare coverage.

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)

Opportunity House's TH/RRH project leverages mainstream family service systems by connecting participating families directly to public benefits and community resources that supplement project assistance and ensure long-term housing stability. Beginning at intake, housing case managers conduct comprehensive benefit screenings to assess each household's eligibility and guide participants through applying for and maintaining all available county, state, and federal resources.

For families with children, case managers facilitate connections to Temporary Assistance for Needy Families (TANF) cash assistance, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) food benefits, and Medicaid/Medical Assistance including Child Health Insurance Program (CHIP). Case managers provide hands-on assistance throughout the entire application process, including gathering required verification documents, completing online applications, coordinating transportation or technology for county assistance, and assisting with annual benefit redeterminations to avoid coverage lapses. The program partners with the CoC's SOAR program to assist families that have members with disabilities apply for SSI and SSDI. By systematically integrating these mainstream public funding streams alongside housing and employment support, the project reduces immediate household financial strain, maximizes total available income for essential expenses, and builds a sustainable network of ongoing support as families transition to independent rent payment.

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)

Opportunity House's STEP program provides an integrated model that combines stable housing assistance w/comprehensive wraparound services to foster long-term family stability&self-sufficiency. Case managers partner w/ parents to establish tailored service plans focused on housing stability, employment growth, financial literacy,&goal achievement, guiding families through every phase of independence. Childcare&early education are directly integrated through Opportunity House's two Keystone STARS rated learning centers, providing reliable, high-quality care for children from six weeks old through school age. Programs include infant and toddler care, Pre-K Counts, preschool, before and after school care, homework assistance, and school transportation. By ensuring children are in a safe, developmentally appropriate learning environment, parents gain the reliable coverage necessary to maintain full-time employment or complete educational and training programs. Case managers deliver structured parenting support and guidance to reinforce family stability. Services emphasize positive discipline techniques, child development milestones, household budgeting, and healthy parent-child dynamics. STEP connects pregnant mothers and families with vital maternal and pediatric health resources, including referrals for prenatal and postpartum care, routine child immunizations, vision and dental care, and developmental screenings. Case managers assist with applications for public benefits including Special Supplemental Nutrition Program for Women, Infants and Children (WIC) food benefits, Child Health Insurance Program (CHIP), and Medicaid/Medicare. Connections to local community health centers and behavioral health providers ensure parents &children receive timely medical and mental health interventions to overcome underlying health barriers. The STEP program emphasizes education for the entire family. In addition to early childhood education and K-12 academic enrichment, case managers connect parents with adult literacy, GED completion, vocational training, higher education, and job placement assistance to build sustainable earning potential. By weaving housing stability w/ quality childcare, parental coaching, comprehensive healthcare access, and educational advancement, the STEP program empowers families to break cycles of homelessness and achieve lasting independence

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

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

(limit 500 characters)

The CoC partners closely with the Veteran Multi-Services Center and the local U.S Dept of Vet Affairs for street outreach and connecting veterans and their families to housing, SSVF, VA benefits, and other veteran-specific resources. These partners coordinate referrals, share information through CoC meetings and listserv communications, and work collaboratively to ensure veterans have timely access to supportive services and eligible VA benefits.

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

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

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

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

(limit 500 characters)

The CoC has strong relationships w/ Safe Berks (SB), an organization providing services to survivors of domestic violence, dating violence, sexual assault&stalking. In the CoC, SB is the only organization that is considered a VSP&they provide direct services to clients, and training/support to other providers&the community. They are an active member of the CoC®ularly attend CE&CoC meetings. SB also participates in CoC committees to implement the CoC's strategic plan and improve the system

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)

The CoC works closely w/Connections Work(CW) thru SO to support people transitioning from the justice system&prevent homelessness during reentry. Thru CE&SO people w/ justice-system involvement at risk of or homeless are connected to housing&services while CW addresses reentry needs (ex employment, basic needs&community reintegration). The CoC lead sits on the treatment court advisory board (along w/local government, local jail, DA) ensuring the housing&criminal justice systems work together

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)

The local hospital's street medicine team worked with the CoC to create a medical respite pilot program funded through the state. The CoC identified this as a gap and connected the hospital with the funding. This program will serve people with high medical needs that are discharged from the hospital or rehab, but aren't stable enough to return to shelter or the street. The program will open on Oct 1, 2026 as a pilot with the intention of expansion.

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 CoC lead collaborates with the Berks County Office of Aging to address the needs of older adults experiencing homelessness and CoC staff serves on the Office of Aging's advisory board. This collaboration helps strengthen referrals and coordination for older adults needing supportive services, healthcare, care management, and appropriate housing resources.

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)

EDI operates a CoC-funded Permanent Supportive Housing project that serves individuals experiencing chronic homelessness and who are actively pursuing recovery from substance use disorders. Through Coordinated Entry and the CoC's prioritization process, eligible individuals are connected to EDI's PSH programs in a sober living environment with ongoing supportive services to promote housing stability.

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)

EDI provides comprehensive, integrated behavioral healthcare and supportive services on-site to individuals residing in their PSH program. EDI's trauma-informed and recovery-oriented approach emphasizes safety, collaboration, empowerment, and individual choice. EDI holds multiple required group therapies throughout the day to meet people's varied schedules. The staff on-site are certified recovery specialists and residents are required to meet with their recovery specialists for one-on-one sessions weekly at minimum and to attend daily programming also offered on-site. Available on-site programming includes: "Recovery 101", anger management, nutrition basics class, wellness groups, and relapse prevention.

EDI's certified recovery specialists also connect residents to numerous community partner organizations across a variety of domains such as licensed SUD and mental health treatment, primary care physicians, employment agencies, educational institutions, and other housing projects and programs. This model allows EDI to bring appropriate clinical and supportive services directly to PSH participants, rather than requiring residents to navigate multiple disconnected systems. By combining permanent housing with behavioral healthcare, substance use treatment, case management, peer support, and wellness services, EDI supports residents in maintaining housing and achieving long-term recovery and stability.

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)

All individuals seeking entry into EDI's PSH project are assessed and screened to get a baseline understanding of the individual's needs for various support services. The initial screening is conducted by EDI's admissions coordinator. The initial service needs are identified and initial appointments with external community partners are scheduled, as needed. Upon entry, EDI assigns an embedded certified recovery specialist to every program participant, who the client is required to engage with as they take an active role in their recovery support services. Certified recovery specialists conduct a formal needs assessment and collaboratively create individualized recovery plans (IRP) within 7 days of entry and every 90 days thereafter, often more frequently. Participants are required to meet weekly with their assigned certified recovery specialists to assess their needs, and establish goals and strategies in various domains (addiction recovery, mental health, physical health, financial, employment, family, criminal justice, etc.).

When any assessment determines that a program participant needs a higher level of care, EDI's certified recovery specialists and director of operations coordinate that care and make a referral to an appropriate community partner organization. For example, if a participant resumes active use of substances while in the housing project, the participant is referred for a higher level of care (e.g. residential treatment) and can return to EDI's housing program upon completion of residential treatment. Another example relates to program participants' physical health disabilities that sometimes require hospitalization and physical rehabilitation. When this need is assessed, EDI coordinates that care and the program participant returns to the housing program if safe and appropriate.

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)

EDI's PSH program is structured in phases for program participants, with an overall emphasis on resident engagement and accountability, as described in the organization's Policies and Procedures and Resident Handbook. Residents begin on Phase 1 and are partnered with a certified recovery specialist; they build a foundation in their pathway of recovery and get connected to other services outside of the project and begin searching for employment. Phase 2 residents are defined by sufficient engagement in recovery, securing employment, and paying housing fees. Phase 3 is the transition phase where residents are budgeting and saving money and identifying the specific goals and strategies to exit to a positive destination.

Participants' goals and strategies are assessed and reviewed frequently during residency. Certified recovery specialists use motivational interviewing, strength-based goal setting, crisis deescalation, relapse prevention strategies, and other methods to assist participants in developing their goals and strategies for ultimately transitioning out of EDI's housing program and into self-sufficiency and independent living. The certified recovery specialists are responsible for helping participants identify housing options and support them in housing search. Through the 3-phase approach, program participants are able to build a strong foundation in their recovery, build and practice critical life skills (employment, budgeting, etc.) and intentionally plan for a safe, secure exit to independent living.

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

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

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

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

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

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

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

1D-2a.	Web Posting of CoC-Approved Consolidated Application Before the CoC Program Competition Application Submission Deadline.	
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	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website—which included: 1. the CoC Application, and 2. Project Priority Listings.	09/29/2026
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1D-2b.	Notification to Community Members and Key Stakeholders by Email that the CoC-Approved Consolidated Application is Posted on the Website.	
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	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/29/2026
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1D-2c.	Local Competition Selection Results for All Projects.	
	You must upload the Local Competition Selection Results attachment to the 4A. Attachments Screen.	

	Does your attachment include: 1. Project Names, 2. Project Scores, 3. Project Rank, 4. Project Status—Accepted, Rejected, Reduced Reallocated, Fully Reallocated, 5. Amount Requested from HUD, and 6. Reallocated Funds +/-.	Yes
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1D-2d.	Projects Rejected/Reduced—Notification Outside of e-snaps.	
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1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	07/15/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

1D-2e.	Projects Accepted—Notification Outside of e-snaps.	
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	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	08/03/2026
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1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
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	Describe:
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

1CoC projects are evaluated on their data in a set date range from HMIS, VSP comparable database,&the project app submitted to the CoC. APR scoring criteria assesses outcomes directly related to the CoC&HUD strategic plan, including: reducing LOT&returns to homelessness, increasing employment income, service requirements, involving PWLE. The CoC's Funding Committee reviews this data&the project scores; projects are evaluated against community need/data. The Funding Committee decides which projects are subject to involuntary reallocation due to performance, monitoring concerns&community need. Projects w/ a history of poor performance/spending (2+ yrs)& projects w/ monitoring issues are reviewed by the Funding Committee for potential reallocation. If no new projects are submitted in the competition, the Funding Committee can choose not to reallocate&instead put lower performing/lower priority projects in tier 2. Low performing projects are notified that they have 1 yr to improve performance before involuntary reallocation is considered. Projects wishing to voluntarily reallocate inform the CoC via an Intent to Renew due prior to the competition (6/15/2026)

2The CoC identified 2 low performing projects based on underspending&their scores in the local CoC Competition, and one project that was less needed due to high cost per household. The CoC determined that any housing projects in tier 2 needed to transition to TH as PSH&RRH projects were low priority.

3The less needed project opted to voluntarily fully reallocate. 3 projects voluntarily reallocated to transition and the CoC involuntarily transitioned 6 projects.

4One low performing project specifically serves DV survivors. The Funding Committee opted not to fully reallocate funding b/c the CoC's gaps analysis identified significant housing need for DV survivors. The Committee ranked the project at the bottom of Tier 1 &requested the project reallocate part of the grant to TH; the Committee warned the project that poor performance next year may result in full reallocation.

The other low performing project serves youth ages 18-24 & the Funding Committee opted not to reallocate because the project serves a priority population for the CoC&the project had just finished its 1st year operating. The org informed the CoC an action plan is in place to improve performance; CoC will monitor progress

Other proposed new projects were not a higher priority than these 2 projects serving specific subpopulations

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

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

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

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

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

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

(limit 2,500 characters)

1. Not applicable
2. No changes

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

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

(limit 2,500 characters)

During the 12 month evaluation period (1/23/24 - 1/22/25), the CoC has significantly expanded coordinated outreach, cross system partnerships, and targeted housing interventions to actively engage unsheltered individuals and reduce the 7 established encampments (as reported by Street Outreach) to 5 encampments throughout the geographic region. These efforts have been successful due in part to the expansion of street outreach in Spring 2024. Outreach teams maintain an active weekly presence across known encampments, vehicles, parks, and abandoned buildings. To maximize coverage and early interventions, the CoC regularly meets with public safety professionals, local police departments, and police social workers. Public safety professionals and police department employees actively participate in CoC committees and planning discussions; ensuring key municipal enforcement partners are directly involved in developing collaborative, systemic solutions to address unsheltered homelessness.

To address vehicle residency, the CoC established a Safe Parking Lot initiative. This program provides a securely managed overnight location for individuals living in vehicles while they actively pursue self-sufficiency and housing stability. Participants agree to a time-limited stay in the parking lot while they work toward vital milestones like obtaining a case manager, applying for employment or education, and progressing toward stabilized housing. Outreach staff deploy to the Safe Parking Lot weekly to check in with participants, conduct necessary assessments, evaluate progress, and connect participants directly to available housing resources and case management.

Additionally, the CoC strengthened its partnership with local Street Medicine providers to deliver critical on-site medical care directly in encampments. Medical teams address physical health conditions, behavioral health needs, and substance use treatment directly where individuals reside. Beyond immediate health interventions, Street Medicine providers assist in identifying unsheltered individuals with severe disabilities and complex housing barriers, helping outreach staff prioritize them through Coordinated Entry for Permanent Supportive Housing. Through integrated public safety collaboration, low-barrier healthcare, and direct housing placement, the CoC ensures individuals residing in encampments are safely connected to long-term stability.

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

2A-4b.	Reduce Encampments—Number of People in Encampments.	
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1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	93
2. Enter the reduction in the number of people in encampments during your evaluation period.	21

 nbsp;nbsp;

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

N/A

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

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

(limit 2,500 characters)

The CoC's plan to prevent individuals and families from entering homelessness for the first time, centers on outreach teams strategically expanding their physical presence across key community sites where vulnerable individuals and families naturally gather: public libraries, agencies serving hot meals, and food pantries. Specifically, outreach staff maintain regular, scheduled hours at New Journey Community Outreach's hot lunch program and day center, and City Light Ministries' breakfast programs (both programs serve unhoused people and people at-risk of homelessness). By embedding staff where vulnerable households and individuals naturally gather, outreach workers build direct rapport, identify at-risk families/individuals, and educate them on how to navigate the CE and assessment processes.

The CoC's plan includes having CE staff prioritize problem-solving and shelter diversion strategies when engaging individuals facing imminent homelessness to identify safe housing options outside the shelter system. CE frequently connects people at risk to ESG homelessness prevention funding. A key diversion tactic involves enrolling households in rent, utility, and public benefit assistance through PHARE funding from the state, while simultaneously connecting them to employment and non-employment income. The CoC leverages targeted case management dedicated to job placement and retention for at-risk households, supported by established relationships with local employers and the Workforce Development Board. CoC partner agencies further provide case management focused on service navigation and landlord advocacy, equipping staff and CE assessors to stabilize households in their current housing or rapidly relocate them to prevent shelter entry.

To continue improving and informing the plan, the CoC will analyze System Performance Measures (SPMs), CE data, and direct community feedback, to identify key risk factors for first-time homelessness. CoC, HMIS, and CE staff evaluate multi-year SPM data alongside CE assessments completed with first-time homeless households to analyze core vulnerabilities. To capture emerging trends, the CoC gathers local insights through direct provider meetings, monthly CE case conferencing, monthly Coalition meetings, and ongoing collaboration with the Lived Experience Advisory Panel (LEAP) and Youth Action Board.

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

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

(limit 2,500 characters)

The CoC's plan to reduce the length of time (LOT) individuals and families remain homeless centers on rapid assessment, targeted prioritization, active outreach, and expanded housing navigation. CE plays a critical role in this approach to process and send timely housing referrals within two business days of identifying a housing crisis. Prioritization is managed through the CE assessment tool, which uses LOT homeless combined with compound risk factors (physical and mental health status, eviction history, DV history, etc.) as a primary metric to prioritize households. Households with the highest vulnerabilities and longest LOT homeless are placed on the CE priority list. To ensure rapid placement, the CE Manager meets individually with providers as openings arise, rather than delaying referrals for monthly meetings. Monthly CE case conferencing meetings further allow stakeholders to network resources and fill vacancies efficiently, while discussing households w/ barriers. Complementing this, the Street Outreach team routinely engages long-term unsheltered individuals, building rapport, monitoring their well-being, and continuously offering shelter, housing navigation, and services at every interaction.

To overcome housing search barriers and shorten time in literal homelessness, the CoC has significantly strengthened landlord engagement and housing locator capacity. The CoC has added a dedicated CoC housing navigator position to reduce the amount of time individuals and families remain homeless. This new navigator conducts targeted landlord outreach, identifies available market-rate units, assists clients with housing searches, and administers landlord incentive funds for CoC- funded projects. The program also includes assistance with paying for documents (birth cert, soc security card, ID, etc.), application fees, and other costs that create a barrier to being quickly housed. In 2026, this position has helped an average of 4 households each month. By actively recruiting property owners and mitigating landlord concerns, the Housing Navigator directly accelerates housing placement to unsubsidized units and reduces overall LOT homeless. The CoC has several committees working on implementing the CoC's Strategic Plan. One committee is focused on system navigation and is closely monitoring the system's length of time homeless performance measure.

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?	64.91%

Describe how you calculated the data for this response.

(limit 2,500 characters)

To calculate this data point, HMIS staff ran a report that included all transitional housing, permanent supportive housing, and rapid rehousing programs in the CoC's HMIS. The staff member ran an Annual Performance Report (APR) on a reporting group consisting of all of these program types for the date range of 1/1/25 - 12/31/25. The data was taken from the section of the APR titled "23c - Exit Destination - All persons". The number of people counted in the following data points were summed:

- Staying or living with family, permanent tenure
- Staying or living with friends, permanent tenure
- Rental by client, no ongoing housing subsidy
- Owned by client, no ongoing housing subsidy

This total was then divided by the total number of exits for the 12 months to get the percentage of exits to unsubsidized housing.

2A-8.	Housing Inventory Count (HIC) and Point-in-Time (PIT) Count Date.	
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	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/28/2026
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2A-8a.	HIC and PIT Count Data—HDX 2.0 Submission Date.	
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	Did your CoC submit its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count data in HDX 2.0 by April 30, 2026, 8:00 p.m. EDT?	Yes
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2A-8b.	Longitudinal System Analysis (LSA) Data—HDX 2.0 Submission Date.	
	You must upload your CoC's FY 2026 HDX Competition Report to the 4A. Attachments Screen.	

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

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	295	81	225	59.84%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	177	0	77	43.50%
4. Rapid Re-Housing (RRH) beds	61	45	106	100.00%
5. Permanent Supportive Housing (PSH) beds	385	0	385	100.00%
6. Other Permanent Housing (OPH) beds	39	0	39	100.00%

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

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

(limit 2,500 characters)

1 The CoC's largest privately-funded shelter, Hope Rescue Mission, opted out of sharing data in early 2025 which solely contributed to a low bed coverage rate for both emergency shelter and transitional housing project types. The CoC lead agency (also the CoC's HMIS lead agency) recognizes the importance of this data and therefore has taken the following steps since then and will continue to take the following steps:
Offer to cover all HMIS license fees
Provide dedicated training and education to staff on HMIS
Set up and pay for a data import to export data from their system and import it into HMIS
Simplify the intake process and data collection to match their current workflow
Provide detailed explanation about the importance of data sharing with open dialog to hear concerns
2 The CoC staff will provide the above details from question 1 in writing to the shelter and offer in writing to cover the HMIS licensing fees. CoC HMIS staff have already worked with the HMIS vendor to create the import process so it is ready if the shelter decides to contribute data; the shelter is aware that this process is in place and ready to be used. HMIS staff have prepared training guides and resources for the shelter to make the set up process as easily and seamless as possible. CoC and HMIS staff have had several meetings over the past year and will continue to dialog with the shelter through phone calls, emails, and meetings (both virtual and in-person), about the importance of data sharing, the benefit to shelter's clients, and the benefit for the community, while hearing, responding to, and troubleshooting their concerns.

3A. Policy Initiatives

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

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

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

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

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

Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes?

No

4A. Attachments Screen For All Application Questions

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

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

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

1.	You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.		
2.	You must upload an attachment for each document listed where 'Required?' is 'Yes'.		
3.	We prefer that you use PDF files, though other file types are supported—please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.		
4.	Attachments must match the questions they are associated with.		
5.	Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process.		
6.	If you cannot read the attachment, it is likely we cannot read it either.		
	. We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).		
	. We must be able to read everything you want us to consider in any attachment.		
7.	After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.		
8.	Only use the 'Other' attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.		
Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	List of TH/RRH/PS...	09/30/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	List of CoC Progr...	09/30/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	Language from Pro...	09/30/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	Evidence of Coord...	09/28/2026
05. 1D-1. Local Competition Scoring Tool	Yes	Local Competition...	09/28/2026

06. 1D-2c. Local Competition Selection Results	Yes	Local Competition...	09/29/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	FY 2026 HDX Compe...	09/28/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No	HUD-2996 Certific...	09/29/2026
09. 3A-2a. Project List for Other Federal Statutes	No		
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No	Your CoC's Policy...	09/28/2026
11. Other	No		

Attachment Details

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

Attachment Details

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

Attachment Details

Document Description: Language from Project Supportive Service Agreements

Attachment Details

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

Attachment Details

Document Description: Local Competition Scoring Tool

Attachment Details

Document Description: Local Competition Selection Results

Attachment Details

Document Description: FY 2026 HDX Competition Report

Attachment Details

Document Description: HUD-2996 Certification for Opportunity Zone
Preference Points

Attachment Details

Document Description:

Attachment Details

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

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/27/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/28/2026
1C. Coordination and Engagement	09/29/2026
1D. Project Review/Ranking	09/29/2026
2A. HMIS Implementation	09/29/2026
3A. Policy Initiatives	09/27/2026
4A. Attachments Screen	09/30/2026
Submission Summary	No Input Required

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

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

Documents include the following:

- **Chart detailing applicant, project name, project type, and organization that provides substance use treatment on-site**

The chart contains all of the CoC's housing projects, therefore 100% of the CoC's TH, RRH, and PSH projects have substance use treatment on site.

1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment			
Applicant Name	Project Name	Project Type	Treatment Provider
Berks Coalition to End Homelessness, Inc	Berks Youth RRH FY 2026	RRH	Awaken (program through TASC)
Berks Counseling Center, Inc.	BCC Leasing Assistance 1 Permanent Housing	PSH	Berks Counseling Center's treatment programs
Berks Counseling Center, Inc.	BCC Franklin St. Transition to TH	TH	Berks Counseling Center's treatment programs
Berks Counseling Center, Inc.	BCC Leasing Assistance 2 Transition to TH	TH	Berks Counseling Center's treatment programs
Berks Counseling Center, Inc.	BCC 239 S 5th St. Transition to TH	TH	Berks Counseling Center's treatment programs
Berks Counseling Center, Inc.	BCC PS Recovery Permanent Housing	TH	Berks Counseling Center's treatment programs
Easy Does It, Inc.	Easy Does It, Inc. Recovery Housing	TH	Certified Recovery Specialists on staff
Opportunity House	Linkages to New Beginnings	TH	Recovery Coaching Services
Pennsylvania Coalition Against Domestic Violence	PA0920 FY26 Renewal Safe Berks	RRH	Recovery Coaching Services
Pennsylvania Coalition Against Domestic Violence	Berks County DV TH Transition FY26	TH	Berks Counseling Center's treatment programs
Pennsylvania Coalition Against Domestic Violence	Berks County NEW DV TH FY26	TH	Berks Counseling Center's treatment programs
Service, Access, & Management, Inc.	Shelter Plus Care Renewal 2026	PSH	Awaken (program through TASC)
The Salvation Army	The Salvation Army Reading Transitional Housing Program	TH	Caron Outpatient Treatment Center, Recovery Coaching Services
The Salvation Army, a New York Corporation	Salvation Army Reading Consolidated PSH	PSH	Caron Outpatient Treatment Center, Recovery Coaching Services

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

**1C-1f. List of CoC Program Projects and
Number of Units that Require Substance
Abuse Treatment**

Documents include the following:

Chart detailing:

- **Applicant name**
- **Project name**
- **Project type**
- **Total number of units**
- **Number of units requiring substance abuse treatment as a condition of continued participation in the program in accordance with 24 CFR 578.75**

Number of people reporting chronic substance use identified in the 2026 PIT count: 106

Number of units required SUD treatment: 67

Applicant	Project	Type	# Units	# Units w/ Treatment Requirement
Berks Coalition to End Homelessness, Inc	Berks Youth RRH FY 2026	RRH	22	0
Berks Counseling Center, Inc.	BCC Leasing Assistance 1 Permanent Housing	PSH	17	0
Berks Counseling Center, Inc.	BCC Franklin St. Transition to TH	TH	13	13
Berks Counseling Center, Inc.	BCC Leasing Assistance 2 Transition to TH	TH	12	0
Berks Counseling Center, Inc.	BCC 239 S 5th St. Transition to TH	TH	6	6
Berks Counseling Center, Inc.	BCC PS Recovery Transition to TH	TH	8	8
Easy Does It, Inc.	Easy Does It, Inc. Recovery Housing	TH	40	40
Opportunity House	Linkages to New Beginnings	TH	9	0
Opportunity House	STEP (Supporting Transitions Through Empowerment & Progression)	Joint TH&RRH	7 (TH)	0
Opportunity House	STEP (Supporting Transitions Through Empowerment & Progression)	Joint TH&RRH	15 (RRH)	0
Pennsylvania Coalition Against Domestic Violence	PA0920 FY26 Renewal Safe Berks	DV RRH	14	0
Pennsylvania Coalition Against Domestic Violence	Berks County DV TH Transition FY26	DV TH	15	0
Pennsylvania Coalition Against Domestic Violence	Berks County NEW DV TH FY26	DV TH	10	0
Service, Access, & Management, Inc.	Shelter Plus Care Renewal 2026	PSH	53	0
The Salvation Army	The Salvation Army Reading Transitional Housing Program	TH	4	0
The Salvation Army, a New York Corporation	Salvation Army Reading Consolidated PSH	PSH	32	0
TOTAL			277	67

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

1C-3. Language from Project Supportive Service Agreements

Documents include the following:

- **Agreement from Salvation Army**
- **Excerpts from Service Access Management (SAM)'s agreement**
- **Agreement from Safe Berks (PCADV's subgrantee)**
- **Excerpts from Opportunity House's agreement**
- **Excerpt from Berks Counseling Center's resident handbook**
- **Berks Counseling Center's form for clients to agree and acknowledge the handbook**
- **Excerpt from Easy Does It. Inc's resident handbook**
- **Easy Does It. Inc's form for clients to agree and acknowledge the handbook**
- **Excerpt from Berks Coalition to End Homelessness's agreement**



The Salvation Army of Reading –Transitional Housing Program Case Management Agreement

Purpose:

The purpose of this Supportive Service Agreement is to ensure that participants enrolled in The Salvation Army's Transitional Housing Program receive the services needed to stabilize, work towards self-sufficiency, and transition to permanent housing.

Expectations of Supportive Services:

Participants are provided with 20 hours of customized supportive service throughout the week and are expected to attend the scheduled activities.

All supportive services exist to aid a participant in making progress in their goals. These services are designed to be beneficial for participants and the topics and needs of supportive services that are offered are assessed by:

- Case management meeting (Weekly, Bi-Weekly or as scheduled)
- Creating and maintaining progression as service plan
- Engaging in life skills, employment services, financial literacy, and other programs activities.
- Participating in treatment services if applicable (mental health, substance use, recovery support groups)
- Attending medical, dental, and specialty appointments as needed
- Complying with program rules, safety policies and housing standards.

Types of Supportive Services offered, but not limited to:

- One-on-one intensive case management
- Recovery support (Referrals to appropriate agencies)
- Therapeutic activities
- Life skills training (budgeting, cooking, parenting, tenant rights)
- Health coordination (primary care, dental, behavioral, specialty care)
- Mental health coordination
- Employment and job readiness
- Volunteer opportunities
- Financial literacy
- Saving's program
- Tenant Rights

Duration of Agreement:

Agreement remains in effect for the duration of your participation in The Salvation Army's Transitional Housing Program. It will be reviewed and updated as part of your case management and service plan updates.



The Salvation Army of Reading –Transitional Housing Program Case Management Agreement

Acknowledgement:

Participants are responsible for following through on their supportive services goals and communicating to their case manager if there are any barriers or additional support that is needed. Participants are encouraged to communicate with their case manager concerning meeting times and appointments.

I, _____, want to engage in supportive services and will collaborate with the case manager to maintain this expectation. I understand that if any barriers do arise, I will meet with my case manager and plan our next steps. I understand that program participants that are over the age of 62, or who have a physical disability or developmental disability may be exempt from supportive services goals. I understand this does not include substance abuse disorders.



The Salvation Army of Reading –Transitional Housing Program Case Management Agreement

Case Management Agreement

Case management services are client-orientated and goal-orientated to support participants in making progress on their goals. The case manager is available to offer emotional support throughout the week to participants and can offer referrals to other community support and resources. *The case manager and participant will meet weekly to work on any outstanding goals and follow up on things the participants and/or case manager have been working on.* These meetings can be flexible, and there may be a quick check-in in person. The case manager will follow up with participants if there are programmatic concerns, which may lead to mediation meetings if conflict arises between the participant and landlord. The case manager can be present in those meetings to act as support for the participant.

Participants are responsible for following through on their case management goals and communicating with the case manager if there are barriers or additional support that is needed. Participants are asked to communicate with the case manager concerning meeting times and appointments.

I, _____, willingly want to engage with case management services. *I will collaborate with the case manager to create a goal(s) for my duration in The Salvation Army's Transitional Housing Program. I understand that my thoughts and priorities are of utmost importance in the case management process, and that I have the choice and power to inform what case management can look like.*

I understand the case manager's role as a therapeutic support for all participants with The Salvation Army's Transitional Housing Program.

I understand my case is confidential within The Salvation Army and that all information and data is kept in confidence. I understand that The Salvation Army will only disclose information required for referrals to best support and coordinate external resources. I understand that my case manager will not share my information with anyone outside of The Salvation Army without a signed Release of Information giving my permission. I understand the only instance in which The Salvation Army will release my information is if I disclose that I want to hurt myself, someone else, or if I disclose that child abuse has occurred.

I understand that The Salvation Army maintains electronic case records using Service Point software.

I will communicate with my case manager if I have any questions or concerns regarding the case management process at The Salvation Army.

By signing this consent, you are authorizing The Salvation Army to maintain an electronic case file on your behalf, and that you agree to participant in the required case management agreement.

Participant Signature

Date

Staff Signature

Date

RAPID REHOUSING PROGRAM AGREEMENT

Rapid rehousing provides services and temporary rental assistance, as needed, to assist participants quickly obtain and maintain permanent housing. Program staff will partner with you to create a housing stability plan with short-term goals that you set that are focused on:

- (1) obtaining an apartment that you will lease directly from a private landlord, and
- (2) preparing you to maintain and afford that apartment as program assistance decreases and ends.

Rental assistance could end before the end of your lease term and is not guaranteed if funding becomes unavailable. Participants with no, or insufficient income to afford rent must have at least one goal to increase or gain income in order to afford their apartment. Program staff will work with you to find an apartment, understand your lease obligations, help you budget, and connect you to services in the community as needed to meet your goals.

Program staff will review your housing stability plan with you at least once a month to assess progress, assist with issues, update your plan as necessary, and inform you about the availability of ongoing funding. If you are not making sufficient progress towards finding an apartment or affording and maintaining that apartment, program staff will help explore other housing options with you.

I agree to:

- Be an active participant in Safe Berks' RRH Program;
- Consider my budget when selecting an apartment that I can reasonably expect to afford and maintain on my own after temporary rental assistance from this program ends;
- Take all necessary steps to accomplish the goals outlined in my housing plan and explore referral resources suggested to me by program staff to ensure my housing stability;
- Keep all appointments and meet with program staff at least once a month to receive important updates about the ongoing availability of funding, and to discuss progress on my housing goals. If I am unable to keep an appointment (phone, office visits, virtual appointments), I will attempt to reschedule the appointment within 24 hours;
- Fulfill my obligations as outlined in the lease and maintain the rental unit in good condition to ensure the return of the security deposit;
- Pay my portion of the rent on time and immediately inform program staff if there is a payment issue and/or I receive any communication from my landlord that affects continued tenancy; and,
- Provide all information and documentation (such as income documentation and changes to family composition) to program staff as required.

Program participant (Print): _____

Program participant (Sign): _____ Date: _____

Program Staff (Sign): _____ Date: _____

Note: Safe Berks is a victim service provider and cannot legally require services, however as per the language above, Safe Berks requires participants to be active in case management and progress on goals.

SERVICE ACCESS & MANAGEMENT, Inc.

SHELTER + CARE PROGRAM - PARTICIPANT CASE MANAGEMENT AGREEMENT

The mission of Service Access & Management, Inc. is to help people throughout our service area enhance the quality of their lives by effectively and efficiently managing and/or providing needed, accessible and individually satisfying human services. Our vision is that “Everyone we meet, we leave better off.”

Shelter + Care Program Case Management Expectation & Agreement:

Participants in the Shelter + Care Program (“S+C Program”) are required to be active participants in case management services. These case management services may be provided by any licensed, local (Berks County, PA) mental health and/or substance use disorder case management provider agency, including but not limited to SAM, Inc. Participants are able to choose both their provider and specific case manager and may choose to change their choice of provider and/or case manager at any time.

Your Case Manager Will:

- Work with Coordinated Entry to process referrals to the S+C Program
- Maintain contact necessary to ensure that all lease obligations are being met.
- Contact SAM Associate Housing Coordinator with any changes in income, status, or service plan.
- Gather information required for Annual Review
- Assist with the preparation for any appt. by gathering information or completing documents.
- Attend any meetings regarding program compliance issues.
- Assist Participant in meeting all Annual Review requirements
- Assist Participant in applying for alternative subsidized housing programs if so desired by participant
- Assist Participant when the participant has reached a point of self-sufficiency such that case management services are no longer required and the participant may be identified as a Graduate Candidate from the S+C Program

An Associate Housing Coordinator – within the SAM, Inc. (Berks) Housing Department - works directly with the case management and support teams

Service Access & Management

for each individual S+C Program participant, ensuring all program requirements are met and all required reporting and documentation are kept.

Failure by participants to engage and remain active in case management and support services during the full duration of their participation in the S+C Program will result in termination from the program, in the event any and all attempts to assist the participant in re-engagement with case management services and supports are unsuccessful.

SAM, Inc. will seek termination from the S+C Program only when all efforts have been identified, utilized and exhausted by case management and all involved partners and participant teams in keeping participants housed.

Case Management and support teams will work diligently to ensure S+C Program participants are aware of potential violations of their HAP contract. SAM, Inc. may routinely identify reasonable concessions that can be made in order to keep participants successfully housed and continued participants in the S+C Program. Negative terminations from the S+C Program are kept to a minimum by very strong and robust collaboration between SAM, Inc., case management and support teams. Such situations may entail participants voluntarily choosing to leave the program against the advice of their support teams, failure to engage with case management such that negative situations cannot be addressed in time to resolve issues and thereby prevent termination, evictions that absolutely cannot be mitigated and/or prevented, and non-compliance with HUD requirements which absolutely cannot be resolved by any and all means possible.

Basic Case Management Descriptions:

Mental health and/or substance abuse services consist of Blended Case Management and Certified Peer Specialist or Recovery Coach Services. Services are funded through Medicaid and Behavioral Health Managed Care organizations. Services may also be supported through county funds.

Service Access & Management

Acknowledgement:

S+C Program participants are responsible for following through on their supportive services goals and communicating to their case manager if there are any barriers or additional support that is needed. S+C Program participants are encouraged to communicate with their case manager concerning meeting times and appointments.

I, _____, a participant in the S+C Program, want to engage in case management and supportive services and will collaborate with my case manager to maintain the expectation that active and on-going engagement with case management and support services is a requirement of participation in the S+C Program. I understand that if any barriers do arise, I will meet with my case manager and plan our next steps, in order to avoid failure to meet this expectation and subsequent termination from the S+C Program.

By signing this consent, I am authorizing SAM, Inc. to maintain an electronic case management file on my behalf, and that I agree to participate in the required case management and support services expectations of the S+C Program.

Participant Signature

Date

Staff Signature

Date



2. PARTICIPANT RESPONSIBILITIES

As a participant in RRH, I agree to:

- Work with my Opportunity House case manager toward housing stability.
- Communicate with my case manager and attend scheduled appointments.
- Provide requested documentation in a timely manner.
- Report changes in income, employment, household composition, or housing circumstances.
- Participate in the housing search and respond to reasonable housing opportunities.
- Follow the terms of my lease and maintain my housing appropriately.
- Notify Opportunity House immediately if I receive a notice from my landlord or have a concern that could affect my housing.
- Treat Opportunity House staff, landlords, neighbors, and other individuals respectfully.

3. HOUSING SEARCH AND APPROVAL

Opportunity House will assist with identifying appropriate housing. Participants are expected to actively participate in the housing search.

A unit must be reviewed and approved by Opportunity House before RRH financial assistance can be provided.

Housing approval may require verification of:

- Property ownership;
- Landlord/property management information;
- Rent reasonableness;
- Housing standards;



6. CASE MANAGEMENT

I agree to maintain regular contact with my Opportunity House case manager and participate in housing stability planning.

Case management may include assistance with:

- Housing stability;
- Budgeting;
- Employment and income;
- Benefits;
- Transportation;
- Landlord communication;
- Community resources; and
- Preparing for the end of RRH assistance.

7. HOUSING RESPONSIBILITIES

I understand that I am responsible for following my lease and maintaining my housing.

I agree to:

- Keep my home reasonably clean and safe;
- Report maintenance problems to my landlord;
- Follow applicable property rules;
- Avoid unauthorized occupants;
- Avoid damaging the property; and
- Notify Opportunity House of significant housing problems.



8. PROGRAM EXIT

RRH participation may end when:

- The approved assistance period ends
- The household voluntarily leaves the program
- The household obtains another housing resource
- The household does not participate in required Case Management.

Opportunity House will provide applicable notice and follow program requirements when ending assistance.

Participant Signature and Date

Case Manager Signature and Date

WELCOME

It is the goal of BCC housing programs to provide recovery-based housing opportunities to homeless individuals and families who wish to work toward recovery, independence, and self-sufficiency.

The purpose of this handbook is to let you know about our program and help you become familiar with what is expected of you.

You, as the resident, and we, as the housing staff, have a responsibility to each other. Hopefully, by clarifying these responsibilities at the very beginning, we can better achieve our objective – to provide and maintain quality housing.

It is for these reasons this handbook has been prepared. We hope that you will keep it for future reference while you are a resident with us. **As noted in the lease agreement, this handbook and its attachments are part of the lease and will be enforced in addition to your lease.** Please take the time to read it thoroughly and do not hesitate to contact your case manager if you have any questions.

AGAIN, WELCOME TO YOUR NEW HOME!

SECTION ONE – INTRODUCTION

OFFICE HOURS

Regular hours of office operation are Monday through Friday from 7:30 AM until 4:00 PM. Please feel free to visit or call with service requests or to obtain assistance during office hours. When the office is closed, you may still call and leave a message. **The office telephone number is 610-373-4281 and your case manager is at ext. # _____.** **The number to call for after hour's emergency is the office number. You will then follow prompts.** Please remember that only **EMERGENCY** calls should be made after office hours and on weekends or holidays.

CASE MANAGEMENT - Cell Phone #

All clients are required to meet with Permanent Housing Case Manager a minimum of twice a month. One meeting may be an office or virtual visit and one is a home inspection visit. If for any reason residents need to address personal concerns, general questions or maintenance problems, you are encouraged to call your case manager with your concerns.

SECTION TWO – MOVE-IN

LEASE

The lease is a contract obligation both to the terms and conditions listing within it. On the day set for your lease signing, you will receive a copy of your lease, as well as this handbook. Please read through the lease completely prior to signing it and ask your case manager about anything that you do not understand, or which may require clarification. Consult the lease for renewal procedures. **As noted in the final Article of the Lease this handbook, as well as any other attachments, are all part of your lease.**

PAYMENT OF RENT

Rent is due and payable on or before the first day of each month, if rent is not paid by the 5th day, owner may begin eviction procedures. If you plan to be away for a period of time, rental payment should be made in advance.

Please bring your cash, money order or debit card (NO CHECKS PLEASE) to:
Berks Counseling Center
645 Penn Street, 2nd Floor
Reading, PA 19601

I, _____ acknowledge that I received a copy of the Permanent Supportive Housing Resident Handbook.

Signature

Date

- Curfew for residents who have not obtained employment, or who lose employment, is 7:00 p.m.
- Once residents become employed, they will need to provide a pay stub to the Admission's Coordinator or their recovery support specialist to be copied and kept on file. It is the resident's responsibility to meet with the admissions coordinator or their recovery support specialist and present a current pay stub quarterly or every time they have a change in employment. Failure to do so will result in consequences. In the event the pay stub is paperless, it is the resident's responsibility to obtain the pay stub either online or by mail and have it on hand when making payment.
- Residents may be permitted to forego the full-time work requirement (e.g. valid disability). However, in such cases the resident should still seek part-time employment and must be able to meet all current financial responsibilities and must be engaged in other productive activities (e.g., education, community service, or volunteering).
- Residents are encouraged to consult with their recovery support specialist before accepting or when changing jobs. Residents are expected to be responsible about changing employment (e.g. giving notice, finding a new job).
- Residents who do not regularly pay housing fees (whether from employment or other means) may not have their lease agreement renewed.
- Residents who do not secure and maintain employment within their 1st year (and regularly pay their housing fees) may not have their lease agreement renewed.
- Residents who are seeking social security disability benefits, but who have not been approved within their 1st year may not have their lease agreement renewed.

Recovery Support Services

- Residents are required to complete a needs assessment and individualized recovery plan (IRP) with their recovery support specialist in their first week of admission, and every 90 days. Residents are also required to meet with their recovery support specialist for 1-on-1 sessions weekly, for a minimum of one hour. Residents must schedule meetings in advance with their recovery support specialist, as this illustrates desire for change and commitment to recovery. Failure to meet with your recovery support specialist can result in written warnings and possibly involuntary discharge from the housing program

Sign-In/Sign-Out

- All residents must sign in and out each time they leave or enter EDI. This applies to everything, including, but not limited to, going to a meeting, appointment, work, family, counseling, etc.
- Residents must inform EDI house manager on duty prior to departure and upon return to EDI.



CONSENT TO RESIDENCY

Name of resident: _____

I voluntarily agree to reside at Easy Does It, Inc. I understand and agree that I must participate in treatment, self-help groups, or other drug and alcohol recovery supports outside of this recovery house. I also understand that I am required to abstain from the use and sale of alcohol and illicit drugs. Furthermore, I will pay my rent on time. I may discontinue residency at any time.

Signature of resident: _____

Date: _____

Staff signature: _____

Date: _____

MEMORANDUM OF UNDERSTANDING

Program Participation & Responsibilities

- Maintain monthly contact with your Case Manager and schedule regular residential visits.
- Work on developing a plan with your Case Manager which is focused on housing stability and increased independence.
- Inform your Case Manager of any problems related to housing or services and work together in resolving any issues.
- Ensure that you understand and abide by the requirements contained in the Lease. Ensure that any guests you have at your residence also follow the lease terms.
- Inform your Case Manager about changes to any household members or income within 15 days of the change, including:
 - Increases or loss of income, and changes in employment.
 - Changes in household members. Any household members requesting to join the program or become a party to the Lease must be approved by the program first and the Landlord.
 - You require live-in aide. A live-in aide must first be approved by the program.
- After income or household change is reported, you should supply documents needed to verify your rent portion or continued eligibility within 30 days of the change. Providing false information in connection with federal assistance is fraud and will result in dismissal from the program.
- Make timely payments of your portion of rent and utilities when applicable. If you are unable to pay your rent, contact your Case Manager immediately.
- Maintain residence in your unit through the lease term. The program will not fund the unit if you leave for over thirty (30) days, absent a permitted leave, such as the need for medical care, admission to a treatment program, and/or incarceration. Documentation must be submitted to your Case Manager.

Frequently Asked Questions

What does Case Management look like?

- We will join you to see potential units, help you submit applications, and be there at Lease signing and move-in.
- We will provide direct services or link you to other community resources as necessary.
- We will maintain regular contact with you, including home visits. You can expect more frequent visits right after you move in.

What kind of home can I get?

- We work with landlords that participate with housing programs.
- The unit must pass a safety inspection to make sure everything is safe and working.

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

**1C-10. Evidence of Coordination and
Non-Interference with Local Efforts to Advance
Public Safety**

Documents include the following:

- **Letter from Reading Police Department on their letterhead detailing the partnership between the CoC and the department. Reading is the largest city in the CoC's area with the highest concentration of unsheltered people.**



JAVIER RUIZ
CHIEF OF POLICE

CITY OF READING, PENNSYLVANIA

POLICE DEPARTMENT
815 WASHINGTON STREET
READING, PA 19601-3690
PHONE - (610) 655-6415
FAX - (610) 655-6400

September 22, 2026

To Whom It May Concern,

On behalf of the Reading Police Department, I am writing to express our support for the Berks Coalition to End Homelessness (BCEH), the lead agency for PA-506 Continuum of Care.

Our department works closely in collaboration with BCEH to address the complex challenges surrounding unsheltered homelessness in the City of Reading, including decreasing the public use of illicit drugs. On September 3rd, 2026, our officers and department social workers met with BCEH outreach staff and other local service providers to strategize on ways to address encampments in the Continuum of Care's geographic area.

Before conducting encampment sweeps, we notify BCEH so the street outreach team can engage individuals on-site ahead of law enforcement to assess needs, resolve housing barriers, and connect residents to support services and shelter. BCEH and street outreach staff do not interfere with or impede our efforts to address encampments.

Additionally, our police department social workers contact BCEH street outreach when encountering unhoused individuals on patrol or calls. Outreach team members deploy directly to the scene to provide immediate, trauma-informed support. This collaborative model allows us to maintain public safety while prioritizing long-term housing solutions.

The Reading Police Department values BCEH as a community partner. Their dedication to bridging the gap between public safety and supportive social services contributes to a safer, more compassionate community.

Sincerely,

A handwritten signature in blue ink, appearing to read "Javier Ruiz", is written over a large, stylized blue ink flourish.

Javier Ruiz

Chief of Police



FY 2026

PA-506 - Reading/Berks County

Continuum of Care

1D-1. Local Competition Scoring Tool

Documents include the following:

- **Renewal project scoring tool**
 - **Threshold requirements (all projects)**
 - **Scoring criteria**
 - **DV-specific assessment**
- **New project scoring tool**
 - **Threshold requirements (all projects)**
 - **Scoring criteria**
 - **TH threshold requirements**
 - **SSO threshold requirements**
 - **SSO-SO threshold requirements**

CoC Competition Scoring Tool FY 2026 Renewal Projects Threshold Requirements

CoC Threshold

For each requirement, select "Yes" if the project has provided reasonable assurances that the project meets the requirement.

- | | Yes/No |
|---|--------|
| 1. Project participates with Coordinated Entry. (24 CFR 578.23(c)(9)) | Yes |
| 2. Applicant is active participant in 75% of the CoC meetings in the last 12 months (CoC Lead will provide) | Yes |
| 3. Project has verified participant eligibility - all clients came from eligible locations prior to project entry (CoC/HMIS Lead will provide) 24 CFR 578.103(a)(3)&(4); 24 CFR 576.500(b) or (c) | Yes |
| 4. Acceptable organizational audit or financial review (2 CFR 200 subpart F) | Yes |

HUD Threshold Yes/No

- | | |
|--|-----|
| 1. Applicant has active SAM/UEI registration with current information | Yes |
| 2. Applicant has valid DUNS number in application | Yes |
| 3. Applicant has no outstanding delinquent federal debts, or:
a negotiated repayment schedule is established and the repayment schedule is not delinquent, or
other arrangements satisfactory to HUD are made before the award of funds by HUD | Yes |
| 4. Any violations of Federal criminal law have been disclosed | Yes |
| 5. Demonstrated the population to be served meets program eligibility requirements as described in the Act, and project application clearly establishes eligibility of project applicants (24 CFR 578.103(a)(3)&(4); 24 CFR 576.500(b) or (c)) | Yes |
| 6. Applicant has no debarments and/or suspensions | Yes |
| 7. Project agreed to the required certifications as specified in the NOFO | Yes |
| 8. Project is actively using HMIS (or comparable database, if domestic violence provider) (24 CFR 576.500(b) or (c); 24 CFR 578.103(a)(3)) | Yes |
| 9. Applicant affirms they will not engage in illegal racial discrimination, consistent with 2 CFR 200.300.a. | Yes |
| 10. Applicant affirms they will not operate drug injection sites or "safe consumption sites," knowingly permit the use or distribution of illicit drugs on property under their control, or knowingly distribute drug paraphernalia on or off of property under their control. | Yes |

Threshold Subtotal (out of 14) | 14

**CoC Competition Scoring Tool FY 2026
Renewal Projects**

Project Name:		Project Type:					
Organization:		Date of review:					
A. Housing Stability		Point Range:	Points Awarded:	Max Point Value:	Source: **	Comments:	Criteria Type
A1.	Percentage of households achieving permanent housing upon exit or retained housing in program	10 pts - 95%+ achieved/retained PH 8 pts - 90%-94% achieved/retained PH 6 pts - 85%-89% achieved/retained PH 4 pts - 80%-84% achieved/retained PH 2 pts - 75%-79% achieved/retained PH 0 pts - less than 75% achieved/retained PH		10	APR Q23c		System performance
A2.	Percentage of exits to permanent housing that return to homelessness within 6 - 12 months. <i>DV specific projects are exempt from this criteria, however DV projects will have the opportunity to gain up to 15 points by responding to the DV Assessment. The CoC recognizes that households cycle between returning to the abuser and homelessness multiple times before breaking ties with the abuser.</i>	15 pts - 0% return to homelessness 10 pts - 1%-5% return to homelessness 7 pts - 10% - 6% return to homelessness 5 pts - 11%-15% return to homelessness 0 pts - more than 16% return to homelessness		15	System Performance Measure (HMIS) or DV Assessment		System performance Returns to homelessness
A3.	Program Average Length of Stay for stayers	5 points - 6 months or more (RRH) 5 points - 12 months or more (PSH)		5	APR Q22b		Objective
A4.	Length of Time between Project Start Date and Housing Move-in Date	5 pts - Average less than 30 days 4 pts - Average between 31-40 days 3 pts - Average between 41-50 days 2 pts - Average between 51-60 days 0 pts -Average more than 60 days		5	APR Q22C		Objective
A5.	Percentage of unknown exit destinations	5 pts - 0% unknown exits OR no exits 3 pts - 1%-10% unknown exits 1 pts - 20% - 11% unknown exits 0 pts - more than 20% unknown exits		5	APR Q23c		System performance Decreasing unknown exits
A6.	Percentage of exits to unsubsidized housing	5 pts - 100%-90% OR no exits 4 pts - 89%-80% exits to unsubsidized housing 3 pts - 79%-70% exits to unsubsidized housing 2 pts - 69%- 60% exits to unsubsidized housing 0 pts - less than 60% exits to unsubsidized housing		5	APR Q23c		System performance Increasing exits to unsubsidized housing
B. Access to Income and Mainstream Resources		Point Range:	Points Awarded:	Max Point Value:	Source: **	Comments:	Criteria Type
B1.	Participants with one or more source of non-cash benefits by program exit or at annual assessment if there are no exits. (Includes SNAP, WIC, and TANF-funded services)	5 pts. - more than 80% 3 pts. - 65 to 79% 1 pts. - 50 to 64% 0 pts. - 49% or less		5	APR Q20b		System performance
B2.	Program participants increased <u>employment</u> income.	10 pts - more than 51% 8 pts - 41%-50% 6 pts - 31%-40% 4 pts - 21%-30% 2 pts - 10%-20% 0 pts - less than 10%		10	APR Q19a1		System performance Increasing employment income

C. Severity of Need		Point Range:	Points Awarded:	Max Point Value:	Source: **	Comments:	Criteria Type
Permanent Supportive Housing Projects (program specific, disregard if not applicable)			Points Awarded:	Max Point Value:	Source: **	Comments:	
C1.	Percentage of adults with zero income at entry	5 pts - ≥ 30% zero income at entry 4 pts - 25% - 29% zero income at entry 3 pts - 20%-24% zero income at entry 2 pts - 10-19% zero income at entry 0 pts - ≤ 9% zero income at entry		5	APR Q16		Objective
C2.	Percentage of adult participants with 2 or more disabling conditions at entry	5 pts - 100% with 2+ disabling conditions 4 pts - 90% - 99% with 2+ disabling conditions 3 pts - 80% - 89% with 2+ disabling conditions 2 pts - 70% - 79% with 2+ disabling conditions 0 pts - ≤ 69 % with 2+ disabling conditions		5	APR Q13a2		Objective
C3.	Percentage of adults participants entering project from place not meant for human habitation (PNMHH)	5 pts - ≥ 35% entering from PNMHH 4 pts - 25% - 34% entering from PNMHH 3 pts - 15% - 24% entering from PNMHH 2 pts - 5% - 14% entering from PNMHH 0 pts - ≤ 4% entering from PNMHH		5	APR Q15		Objective
C4.	Percentage of all households who were chronically homeless upon entry	5 pts - 100% chronic at entry 3 pts - 90% - 99% chronic at entry 0 pts - 0% - 89% chronic at entry		5	APR Q26a		Objective
C5.	Percentage of adult participants reporting substance abuse at entry	5 pts - ≥ 50% reported SA at entry 4 pts - 40% - 49% reported SA at entry 3 pts - 30% - 39% reported SA at entry 2 pts - 20% - 29% reported SA at entry 0 pts - ≤ 19% reported SA at entry		5	APR Q13a1		Objective
C6.	Percentage of adult participants reporting DV history at entry	5 pts - ≥ 25% recent DV history at entry 4 pts - 20% - 24% recent DV history at entry 3 pts - 15% - 19% recent DV history at entry 2 pts - 10% - 14% recent DV history at entry 0 pts - ≤ 9% recent DV history at entry		5	APR Q14a		Objective
C7.	Program participants connected to health insurance at exit or annual assessment if there are no exits	5 pts - 100% enrolled in Health Ins 4 pts - 70% - 99% enrolled in Health Ins 3 pts - 40% - 69% enrolled in Health Ins 0 pts - ≤ 39% enrolled in Health Ins		5	APR Q21		Objective
Rapid Rehousing Projects (program specific, disregard if not applicable)			Points Awarded:	Max Point Value:	Source: **	Comments:	
C1.	Percentage of adults with zero income at entry	5 pts - ≥ 25% zero income at entry 4 pts - 19% - 24% zero income at entry 3 pts - 13%-18% zero income at entry 2 pts - 7% - 12% zero income at entry 0 pts - ≤ 6% zero income at entry		5	APR Q16		Objective
C2.	Percentage of adult participants with 2 or more disabling conditions at entry	5 pts - ≥ 10% with 2+ disabling conditions 4 pts - 7% - 9% with 2+ disabling conditions 3 pts - 4% - 6% with 2+ disabling conditions 2 pts - 2% - 4% with 2+ disabling conditions 0 pts - ≤ 1% with 2+ disabling conditions		5	APR Q13a2		Objective

C3.	Percentage of adults participants entering project from place not meant for human habitation (PNMHH)	5 pts - ≥ 25% entering from PNMHH 4 pts - 19% - 24% entering from PNMHH 3 pts - 13% - 18% entering from PNMHH 2 pts - 7% - 12% entering from PNMHH 0 pts - ≤ 6% entering from PNMHH		5	APR Q15		Objective
C4.	Percentage of all households who were chronically homeless upon entry	5 pts - ≥ 9% chronic at entry 4 pts - 6% - 8% chronic at entry 3 pts - 3% - 5% chronic at entry 2 pts - 1% - 2% chronic at entry 0 pts - 0% chronic at entry		5	APR Q26a		Objective
C5.	Percentage of adult participants reporting substance abuse at entry	5 pts - ≥ 10% reported SA at entry 4 pts - 8% - 9% reported SA at entry 3 pts - 6% - 7% reported SA at entry 2 pts - 4% - 5% reported SA at entry 0 pts - ≤ 3% reported SA at entry		5	APR Q13a1		Objective
C6.	Percentage of adult participants reporting recent DV history at entry	5 pts - ≥ 30% recent DV history at entry 4 pts - 23% - 29% recent DV history at entry 3 pts - 16% - 22% recent DV history at entry 2 pts - 9% - 15% recent DV history at entry 0 pts - ≤ 8% DV history at entry		5	APR Q14a		Objective
C7.	Program participants connected to health insurance at exit or annual assessment if there are no exits	5 pts - 70% enrolled in Health Ins 4 pts - 46% - 69% enrolled in Health Ins 3 pts - 36% - 45% enrolled in Health Ins 0 pts - ≤ 35% enrolled in Health Ins		5	APR Q21		Objective
D. HMIS Data Quality		Point Range:	Points Awarded:	Max Point Value:	Source: **	Comments:	Criteria Type
D1.	Average error rate for required data elements in HMIS	5 pts - 2% or less 2 pts - 3% - 5% 0 pts - more than 5%		5	APR Q6a, 6b, 6c		
E. Project Performance		Point Range:	Points Awarded:	Max Point Value:	Source: **	Comments:	Criteria Type
E1.	Unit Utilization	10 pts - 100%-95% 7 pts - 94%-90% 4 pts - 85%-89% 1 pts - 80% - 84% 0 pts - less than 80%		10	SAGE		Objective
E2.	Did the project have any findings during CoC monitoring that were not resolved within the given timeframe?	Deduct 20 points if Yes Deduct 0 points if No or Not Monitored			Monitoring Reports		Objective
E3.	What percentage of CoC funds did the program spend in their last full operating year?	10 pts - 100% expended 8 pts. - 99%-95% expended 5 pts. - 94%-90% expended 0 pts. - less than 90% expended		10	SAGE & GIW		Objective
E4.	Funds are drawn down from eLOCCS at least quarterly. 24 CFR 578.85(c)(3)	5 pts - Minimum of 1 drawdown per quarter 3 pts - Drawdowns 3 of 4 quarters 0 pts - Drawdowns less than 3 of 4 quarters		5	Project representative will provide		Objective
E5.	Was the APR submitted on time? (within 90 days of program end) 24 CFR 578.103(e)	5 pts. - Yes 0 pts. - No		5	SAGE		
E6.	CoC grantee requires participation in services in alignment with CoC and HUD requirements, except where prohibited by federal law	5 pts. - Yes 0 pts. - No		5	Project representative will provide		Service participation

E7.	Project provides on-site behavioral health and/or substance abuse services.	5 pts. - Yes 0 pts. - No		5	Project representative will provide		Promoting treatment and recovery
F. Bonus points		Point Range:	Points Awarded:	Max Point Value:	Source: **	Comments:	Criteria Type
F1.	At least one staff member from the project attended at least one mental health first aid (or similar) training in the past year.	3 pts. - Yes 0 pts. - No		0	Project representative will provide		
TOTAL:			0	140	0.00%		

** Data drawn from HMIS or DV Comparable database

	Total Points	Percent of Total
System Performance Measures	40	35.71%
Objective Criteria	70	50.00%
Returns to homelessness performance, employment income performance, and supportive services participation requirements	30	21.43%

Domestic Violence Assessment (10 pts)

(DV Providers Only)

2 page maximum, single spaced

Please answer the following questions in narrative format:	Points Awarded	Max Point Value
Describe how the project ensures the safety of DV survivors by: ● Training staff on safety planning ● Training staff on trauma-informed, victim centered approaches ● Adjusting intake space to better ensure a private conversation ● Working with survivors to have them identify what is safe for them as it relates to scattered site units and/or rental assistance ● Keeping the location confidential of units used for survivors		10
Describe how the organization measures the projects' ability to ensure the safety of DV survivors the project served (i.e. how does the project capture/evaluate this data).		5
TOTAL	0	15

**DV projects have the opportunity to gain up to 15 points by responding to the DV Assessment*

CoC Competition Scoring Tool FY 2026 New Projects Threshold Requirements

CoC Threshold	Yes/No
1. Applicant participates/will participate with Coordinated Entry <i>(24 CFR 578.23(c)(9))</i>	Yes
2. Applicant agrees to participate in 75% of the CoC meetings in next 12 months	Yes
3. Applicant commits to verifying participant eligibility - all clients came from eligible locations prior to project entry <i>24 CFR 578.103(a)(3)&(4); 24 CFR 576.500(b) or (c)</i>	Yes
HUD Threshold	Yes/No
1. Applicant has active UEI registration with current information or commits to registering upon award.	Yes
2. Applicant has valid DUNS number in application or commits to registering upon award.	Yes
3. Applicant has no outstanding delinquent federal debts, or: a negotiated repayment schedule is established and the repayment schedule is not delinquent, or other arrangements satisfactory to HUD are made before the award of funds by HUD	Yes
4. Any violations of Federal criminal law have been disclosed	Yes
5. Applicant has no debarments and/or suspensions.	Yes
6. Agreed to the required certifications as specified in the NOFO	Yes
7. Agreed to participate in HMIS (or comparable database, if domestic violence provider) <i>(24 CFR 576.500(b) or (c); 24 CFR 578.103(a)(3))</i>	Yes
8. Applicant affirms they will not engage in illegal racial discrimination, consistent with 2 CFR 200.300.a.	Yes
9. Applicant affirms they will not operate drug injection sites or “safe consumption sites,” knowingly permit the use or distribution of illicit drugs on property under their control, or knowingly distribute drug paraphernalia on or off of property under their control.	Yes

**CoC Competition Scoring Tool FY 2026
New Projects**

Project Name:		Project Type:	RRH				
Organization:		Date of review:	7/20/26				
A. Experience		Point Range:	Points Awarded:	Max Point Value:	Source:	Comments:	Criteria Type
A1.	Agency has experience with public funding including HUD grants. Agency has satisfactory drawdowns and performance.	5 pts - Agency has previous experience administering public funds successfully 3 pts - Agency has no previous experience administering public funds, but has a plan to manage the grant 0 pts - Agency has administered public funds but has timeliness issues OR agency has no experience and no plan		5	New project proposal A.1.		Objective
A2.	Agency and sub-recipients (if any) have experience working with the proposed population	5 pts - Experience working with unhoused people <u>and</u> with proposed subpopulation 3 pts - Experience working with unhoused people 1 pt - Experience working with proposed population 0 pts - No experience		5	New project proposal A.2.		Objective
A3.	Agency and sub-recipients (if any) have experience providing housing similar to that proposed in the application	5 pts - Previous experience with all of the following: homeless housing, homeless services, housing location, and/or affordable housing 3 pts - Previous experience with some of the following: homeless housing, homeless services, housing location, and/or affordable housing 0 pts - No experience		5	New project proposal A.2.		Objective
A4.	Agency identifies partners to provide services	10 pts - Demonstrates strategic partnerships that are formalized and integrated into program operations. Clear evidence of formal agreements and referral pathways that leverage external resources to expand capacity and improve participant outcomes. 8 pts - Partnerships are formalized and include defined roles, service delivery, or resource sharing. Informal referral relationships are also described. Partnerships are actively used to support program objectives and enhance service delivery. 6 pts - Identifies partnerships and describes general roles or services. Some may be formalized but details on resource sharing, coordination, or consistent use are limited. 4 pts - Mentions partnerships, but they are loosely defined, lack formalization, or do not clearly describe roles, services, or resources. Limited evidence they are used in practice. 2 pts - Unclear/lacking on partnerships but identifies as a goal with a loose plan in place. 0 pts - Partnerships are not described or are informal with no defined roles. No evidence of coordination or contribution to program objectives.		10	New project proposal A.3.		
B. Program Design		Point Range:	Points Awarded:	Max Point Value:	Source:	Comments:	Criteria Type
B1.	Project will reduce unsheltered homelessness in the community	10 pts - Demonstrates a comprehensive, proactive approach to reducing unsheltered homelessness. Strategies are specific, consistently applied, and responsive to participant needs 7 pts - Clearly describes multiple, defined strategies to reducing unsheltered homelessness. Strategies appear intentional and support ongoing participation. 4 pts - Provides some defined strategies, but approach is uneven, reactive, or missing key components. 1 pts - Mentions and includes general strategies but lacks detail and consistency 0 pts - Question is not addressed or response is minimal. No clear strategies to reducing unsheltered homelessness		10	New project proposal C.2.		System performance Reducing unsheltered homelessness
B2.	Project will present future returns to homelessness	10 pts - Demonstrates a comprehensive, proactive approach to reducing returns to homelessness. Strategies are specific, consistently applied, and responsive to participant needs 7 pts - Clearly describes multiple, defined strategies to reducing returns to homelessness. Strategies appear intentional and support ongoing participation. 4 pts - Provides some defined strategies, but approach is uneven, reactive, or missing key components. 1 pts - Mentions and includes general strategies but lacks detail and consistency 0 pts - Question is not addressed or response is minimal. No clear strategies to reducing returns to homelessness		10	New project proposal C.3.		System performance Returns to homelessness
B3.	Project will help participants increase employment income	10 pts - Demonstrates a comprehensive, proactive approach to assisting clients increase their employment income. Strategies are specific, consistently applied, and responsive to participant needs 7 pts - Clearly describes multiple, defined strategies to assist clients increase their employment income. Strategies appear intentional and support ongoing participation. 4 pts - Provides some defined strategies, but approach is uneven, reactive, or missing key components. 1 pts - Mentions and includes general strategies but lacks detail and consistency or does not address employment income specifically 0 pts - Question is not addressed or response is minimal. No clear strategies to increasing employment income		10	New project proposal C.4.		System performance Increasing employment income
B4. (TH)	Agency has a plan to assist program participants to rapidly secure and maintain permanent housing and emphasizes exit to unsubsidized housing.	10pts - Goals of long-term housing stability and paths of progression are imbedded across program design. Exits to unsubsidized housings are prioritized 7 pts - Program clearly centers on permanent housing or housing progression. Services actively and consistently support movement toward housing stability. Exits to unsubsidized housing are included as a goal. 4 pts - Program includes a housing focus and some services support stability, but approach lacks consistency or clarity. Exits to unsubsidized housing is mentioned without clarity. 1 pt - Program references housing goals but they are not central to design. Services are loosely connected to housing stability. Limited mention of exiting to unsubsidized housing 0 pts - Program does not demonstrate a clear focus on permanent housing or housing progression. Services do not meaningfully support housing stability. No mention of exits to unsubsidized housing		10	New project proposal C.5 and C.6		System performance

B4. (SSO)	Agency has a plan to reach people who are least likely to access homeless assistance, prioritizes people most in need, and takes steps to reduce burdens on people seeking assistance	10 pts - Demonstrates a comprehensive, proactive approach to reaching people and reducing burdens. Strategies are specific, consistently applied, and responsive to participant needs 7 pts - Clearly describes multiple, defined strategies to reaching people and reducing burdens. Strategies appear intentional and support ongoing participation. 4 pts - Provides some defined strategies, but approach is uneven, reactive, or missing key components. 1 pts - Mentions and includes general strategies but lacks detail and consistency 0 pts - Question is not addressed or response is minimal. No clear strategies to reaching people and reducing burdens		10	New project proposal C.7.		System performance
B4. (SO)	Agency has plan to conduct effective street outreach	10 pts - Demonstrates a comprehensive, proactive plan to conduct street outreach. Strategies are specific, consistently applied, and responsive to participant needs. 7 pts - Clearly describes a defined plan to conduct street outreach. Strategies appear intentional and effective. 4 pts - Provides some defined plans, but approach is uneven, reactive, or missing key components. 1 pts - Mentions and includes general plan but lacks detail and consistency. 0 pts - Question is not addressed or response is minimal. No clear plan to conduct street outreach.		10	New project proposal C.8.		System performance
B5.	Type of project proposed	15 pts - TH, SSO, or SSO-SO 0 pts - PSH or RRH		15	New project proposal		Objective
C. Project Performance		Point Range:	Points Awarded:	Max Point Value:	Source:	Comments:	Criteria Type
C2.	Does applicant have a history of submitting APRs on time? (within 90 days of program end)	0 pts - Yes or has not submitted APRs Deduct 10 pts - No	0		Sage		Objective
C3.	Applicant enables/will enable people who are currently or recently unhoused the opportunity to participate in policy making on the board of directors or other equivalent policy making procedures.	5 pts - Applicant has more than one person with lived experience in a policy making position 3 pts - Applicant has 1 person on the board of directors or similar policy making position 1 pt - Applicant does not meet this requirement but identifies as a goal 0 pts - Question is not addressed or response is minimal.		5	New project proposal G.1.		Objective
C4.	Project creates opportunities for people with lived experience to share their expertise and insights.	5 pts - Demonstrates a robust, comprehensive, and proactive plan to create frequent opportunities for people to share insights 3 pts - Clearly describes a plan to collect participant feedback 1 pt - Applicant does not meet this requirement but identifies as a goal 0 pts - Question is not addressed or response is minimal.		5	New project proposal G.2.		
C5.	Project meets threshold criteria for submission	10 pts - Project meets 100% of threshold points 5 pts - Project passes threshold but does not receive full points 0 pts - Project does not meet threshold (project may not be accepted for submission)		10	New project proposal and "Threshold" tab		Objective
D. Financials		Point Range:	Points Awarded:	Max Point Value:	Source:	Comments:	Criteria Type
D1.	Budgeted costs are reasonable, allocable and allowable	5 pts - Budget is appropriate for the project across all requested categories 0 pts - No budget included or costs are not appropriate/allowable		5	New project proposal		Objective
D2.	Match	10 pts - project includes 25% match from non-CoC funds 0 pts - less than 25% match		10	New project proposal		Objective
TOTAL:			0	115	0%		

Objective criteria	60	52%
System Performance Measures	40	35%
Returns to homelessness performance	10	9%
Employment income performance	10	9%
Supportive services participation requirements	included in threshold requirements	

CoC Scoring Tool FY 2026

Transitional Housing Threshold Requirements

New Transitional Housing projects must receive at least 6 out of 8 points available for this project type		Points Awarded:	Max Point Value:	Source:
1	Describe how the project will provide and/or partner with other organizations to provide eligible supportive services that are necessary to assist program participants to obtain and maintain housing.		2	New project proposal
2	Describe your organization's prior experience operating transitional housing or other projects that have successfully helped homeless individuals and families exit homelessness within 24 months. If you do not have experience, describe the plan to meet these requirements.		1	New project proposal
3	Please include your organization's prior outcomes related to exits to permanent housing and increasing income. Please address whether your organization has previously operated or is currently operating transitional housing or another homelessness project where at least 50 percent of participants exit to permanent housing within 24 months and at least 50 percent of participants exit with employment income as reflected in HMIS or another data system used by the applicant. If not, please describe your organization's plan to achieve these outcomes in this project.		1	New project proposal
4	Describe whether the project will be supplemented with resources from other public or private sources, that may include mainstream health, social, and employment programs such as Medicare, Medicaid, SSI, and SNAP.		1	New project proposal
5	Describe how the proposed project will assess the service needs of program participants		0.5	New project proposal
6	Describe how the project will provide individualized services for program participants during their time in Transitional Housing that will result in at least 20 hours per week of engagement in services, activities or employment for all program participants, except for a program participant over age 62 or who is an individual with handicaps as defined in 24CFR 8.3 or a with a developmental disability as defined under 24 CFR 578.3		0.5	New project proposal
7	Indicate that the proposed project will create service plans for each program participant that include: - the services to be provided, when and how often services will be provided, by whom all services will be provided; - program participant goals, strategies for achieving those goals, and target dates for achievement to focus on improved health and wellness, housing stability, and increased employment income leading to financial stability and self-sufficiency.		1	New project proposal
8	Describe why your organization believes that the average cost per household served is reasonable, consistent with 2 CFR 200.404.		1	
TOTAL:		0	8	

CoC Scoring Tool FY 2026
Supportive Services Only Threshold Requirements

New SSO – Standalone project applications must receive at least 4 out of the 5 points available for this project type.		Points Awarded:	Max Point Value:	Source:
1	Describe why this Supportive Services project is necessary to assist people in exiting homelessness, addressing barriers to stable housing, and increasing self-sufficiency. Describe how your organization will conduct an annual assessment of the service needs of the program participants.		1	New project proposal
2	Describe the proposed project's strategy for providing supportive services to eligible program participants including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services.		2	New project proposal
3	Describe whether/how the project will be supplemented with resources from other public or private sources, that may include mainstream health, social, and employment programs such as Medicare, Medicaid, SSI, and SNAP.		1	New project proposal
4	Describe why your organization believes that the average cost per household served is reasonable, consistent with 2 CFR 200.404.		1	New project proposal
TOTAL:		0	5	

CoC Scoring Tool FY 2026
Supportive Services - Street Outreach Threshold Requirements

New SSO project applications that focus on street outreach and indicate so in their project application must receive at least 5 out of the 6 points available for this project type.		Points Awarded:	Max Point Value:	Source:
1	Describe whether/how the project will be supplemented with resources from other public or private sources, that may include mainstream health, social, and employment programs such as Medicare, Medicaid, SSI, and SNAP		1	New project proposal
2	Describe the proposed project's strategy for providing supportive services to eligible program participants including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services.		2	New project proposal
3	Describe whether your organization has a history of partnering with first responders and law enforcement to engage people living in places not meant for human habitation to access emergency shelter, treatment programs, reunification with family, transitional housing or independent living. Describe how your organization will cooperate, assist, and not interfere or impede with law enforcement to enforce local laws such as public camping and public drug use laws and assist/be willing to assist first responders in their efforts to engage homeless individuals		1	New project proposal
4	Describe your organization's experience providing street outreach services for people experiencing homelessness, and how you have demonstrated effectiveness at helping people successfully exit from places not meant for human habitation to emergency shelter, treatment programs, transitional housing or permanent housing programs. If you do not have experience, describe the plan for meeting these requirements.		1	New project proposal
5	Please describe why your organization believes that the average cost per household served is reasonable, consistent with 2 CFR 200.404		1	New project proposal
TOTAL:		0	6	

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

1D-2c. Local Competition Selection Results

Documents include the following:

- **Chart including the following elements:**
 - **Project Names,**
 - **Project Scores,**
 - **Project Rank,**
 - **Project Status—Accepted, Rejected, Reduced
Reallocated, Fully Reallocated,**
 - **Amount Requested from HUD, and**
 - **Reallocated Funds +/-.**

Rank	Applicant	Project Name	Score	Status	Funding Request Amount	Reallocated Funds
Not Ranked	Berks Coalition to End Homelessness, Inc	PA-506 Planning Grant FY 2026	N/A	Accepted	\$312,310	\$0
1	Berks Coalition to End Homelessness, Inc	PA-506 HMIS FY 2026	N/A*	Accepted	\$167,123	\$0
2	Berks Coalition to End Homelessness, Inc	PA-506 Coordinated Entry FY 2026 Renewal	N/A*	Accepted	\$127,877	\$0
3	Opportunity House	STEP (Supporting Transitions Through Empowerment & Progression)	N/A**	Accepted	\$427,859	\$0
4	Berks Counseling Center, Inc.	BCC Leasing Assistance 1 Permanent Housing	85.71%	Accepted	\$292,756	\$0
5	Service, Access, & Management, Inc.	Shelter Plus Care Renewal 2026	84.29%	Accepted	\$818,951	\$0
6	The Salvation Army, a New York Corporation	Salvation Army Reading Consolidated PSH	76.43%	Accepted	\$679,928	\$0
7	Berks Coalition to End Homelessness, Inc	Berks Youth RRH FY 2026	66.43%	Accepted	\$383,719	\$0
8	Pennsylvania Coalition Against Domestic Violence	PA0920 FY26 Renewal Safe Berks	61.43%	Reduced Reallocated	\$665,172	-\$521,209
9	New Journey Community Outreach	New Journey Community Outreach Day Center	92.00%	Accepted	\$318,943	\$0
10	Pennsylvania Coalition Against Domestic Violence	Berks County DV TH Transition FY26	61.43%	Accepted	\$521,209	\$521,209
11	The Salvation Army	The Salvation Army Reading Transitional Housing Program	85.71%	Accepted	\$55,762	\$55,762
12	Opportunity House	Linkages to New Beginnings	81.07	Accepted	\$149,829	\$149,829
13	Easy Does It, Inc.	Easy Does It, Inc. Recovery Housing	75.00%	Accepted	\$653,535	\$653,535
14	Berks Coalition to End Homelessness, Inc	PA-506 Coordinated Entry FY 2026 Expansion	N/A*	Accepted	\$203,281	\$0
15	Berks Counseling Center, Inc.	BCC Franklin St. Transition to TH	85.71%	Accepted	\$327,021	\$327,021
16	Berks Counseling Center, Inc.	BCC Leasing Assistance 2 Transition to TH	87.86%	Accepted	\$275,221	\$275,221
17	Berks Counseling Center, Inc.	BCC 239 S 5th St. Transition to TH	70.00%	Accepted	\$162,372	\$162,372
18	Berks Coalition to End Homelessness, Inc	CoC Street Outreach	96.00%	Accepted	\$150,574	\$80,271
19	Berks Counseling Center, Inc.	BCC PS Recovery Transition to TH	87.14%	Accepted	\$150,370	\$150,370
20	United Way of Lancaster County	211 Housing & Homelessness Resource Navigation	84.00%	Accepted	\$80,000	\$0
21	Pennsylvania Coalition Against Domestic Violence	Berks County NEW DV TH FY26	97.00%	Accepted	\$417,140	\$0
22	Reading Hospital	Street Medicine	85.00%	Accepted	\$191,902	\$0
23	Refresh Berks	Refresh Berks Mobile Shower Program	76.00%	Accepted	\$72,500	\$0

Not Ranked	Berks Coalition to End Homelessness, Inc	PA-506 PSH Project for Veterans 2024	N/A	Fully Reallocated	\$0	-\$80,271
Not Ranked	Berks Counseling Center, Inc.	BCC Franklin St Permanent Housing	N/A	Fully Reallocated	\$0	-\$327,021
Not Ranked	Berks Counseling Center, Inc.	BCC 239 S. 5th St. Permanent Housing	N/A	Fully Reallocated	\$0	-\$162,372
Not Ranked	Berks Counseling Center, Inc.	BCC Leasing Assistance 2 Permanent Housing	N/A	Fully Reallocated	\$0	-\$275,221
Not Ranked	Berks Counseling Center, Inc.	BCC PS Recovery Permanent Housing	N/A	Fully Reallocated	\$0	-\$150,370
Not Ranked	Easy Does It, Inc.	EDI PSH Renewal	N/A	Fully Reallocated	\$0	-\$653,535
Not Ranked	Opportunity House	New Beginnings II	N/A	Fully Reallocated	\$0	-\$83,566
Not Ranked	Opportunity House	Linkages PSH Transition Grant	N/A	Fully Reallocated	\$0	-\$66,263
Not Ranked	The Salvation Army, a New York Corporation	Salvation Army Reading Rapid Rehousing	N/A	Fully Reallocated	\$0	-\$55,762

* Per funding policies, HMIS and CE do not get scored and are automatically ranked at the top of tier 1 as they are system-level requirements

**STEP is in the first year of operating and cannot be scored

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

2A-8b. FY 2026 HDX Competition Report

Documents include the following:

- **PA-506 HDX Competition Report**

2025 HDX Competition Report

2026 Competition Report - Summary

PA-506 - Reading/Berks County CoC

HDX Data Submission Participation Information

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

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

2025 HDX Competition Report

2026 Competition Report - LSA Summary & Usability Status

PA-506 - Reading/Berks County CoC
FY 2025 Reporting Year: 10/1/2024 - 9/30/2025

LSA Usability Status 2025

Category	EST AO	EST AC	EST CO	RRH AO	RRH AC	RRH CO	PSH AO	PSH AC*	PSH CO
Fully Usable	☒	☒	☒	☒	☒	☒	☒	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

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

Measure 1: Length of Time Persons Remain Homeless

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

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

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

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

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, and SH	505	139.2	88.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	599	169.7	106.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

b. This measure is based on data element 3.917

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

Metric	Universe (Persons)	Average LOT Homeless (bed nights)	Median LOT Homeless (bed nights)
1.1 Persons in ES-EE, ES-NbN, SH, and PH (prior to “housing move in”)	729	353.8	187.0
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	817	364.0	199.0

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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	3	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from ES	341	28	8.2%	10	2.9%	16	4.7%	54	15.8%
Exit was from TH	70	4	5.7%	3	4.3%	6	8.6%	13	18.6%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	270	11	4.1%	12	4.4%	13	4.8%	36	13.3%
TOTAL Returns to Homelessness	684	43	6.3%	25	3.7%	35	5.1%	103	15.1%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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	601
Emergency Shelter Total	507
Safe Haven Total	0
Transitional Housing Total	105

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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

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

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

Metric	Value
Universe: Number of adults (system stayers)	162
Number of adults with increased earned income	20
Percentage of adults who increased earned income	12.4%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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)	162
Number of adults with increased non-employment cash income	54
Percentage of adults who increased non-employment cash income	33.3%

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

Metric	Value
Universe: Number of adults (system stayers)	162
Number of adults with increased total income	63
Percentage of adults who increased total income	38.9%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	135
Number of adults who exited with increased earned income	37
Percentage of adults who increased earned income	27.4%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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

Metric	Value
Universe: Number of adults who exited (system leavers)	135
Number of adults who exited with increased non-employment cash income	15
Percentage of adults who increased non-employment cash income	11.1%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	135
Number of adults who exited with increased total income	52
Percentage of adults who increased total income	38.5%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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
Universe: Person with entries into ES-EE, ES-NbN, SH or TH during the reporting period.	459
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.	96
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)	363

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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.	777
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.	183
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.)	594

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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
Universe: Persons who exit Street Outreach	29
Of persons above, those who exited to temporary & some institutional destinations	1
Of the persons above, those who exited to permanent housing destinations	10
% Successful exits	37.9%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

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	537
Of the persons above, those who exited to permanent housing destinations	334
% Successful exits	62.2%

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	492
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	446
% Successful exits/retention	90.7%

2025 HDX Competition Report

2026 Competition Report - SPM Data

PA-506 - Reading/Berks County CoC

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

System Performance Measures Data Quality

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

Metric	All ES, SH	All TH	All PSH, OPH	All RRH	All Street Outreach
Unduplicated Persons Served (HMIS)	508	105	543	244	31
Total Leavers (HMIS)	385	59	117	171	13
Destination of Don't Know, Refused, or Missing (HMIS)	69	3	4	3	7
Destination Error Rate (Calculated)	17.9%	5.1%	3.4%	1.8%	53.9%

2025 HDX Competition Report

2026 Competition Report - SPM Notes

PA-506 - Reading/Berks County CoC

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

Notes For Each SPM Measure

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

2025 HDX Competition Report

2026 Competition Report - HIC Summary

PA-506 - Reading/Berks County CoC

For HIC conducted in January/February of 2026

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current Non-VSP Beds in HMIS or Comparable Database	Total Year-Round, Current, Non-VSP Beds	Removed From Denominator: OPH EHV [†] Beds or Beds Affected by Natural Disaster*	Adjusted*** Total Year-Round, Current, Non-VSP Beds	Adjusted*** HMIS Bed Coverage Rate for Year-Round, Current Beds
ES	376	144	295	0	295	48.8%
SH	0	0	0	0	0	NA
TH	177	77	177	0	177	43.5%
RRH	106	61	61	0	61	100.0%
PSH	385	385	385	0	385	100.0%
OPH	39	39	39	0	39	100.0%
Total	1,083	706	957	0	957	73.8%

2025 HDX Competition Report

2026 Competition Report

PA-506 - Reading/Berks Count

For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Year-Round, Current, VSP Beds in an HMIS-Comparable Database	Total Year-Round, Current, VSP Beds	Removed From Denominator: OPH EHV [†] Beds or Beds Affected by Natural Disaster ^{**}	Adjusted ^{***} Total Year-Round Current, VSP Beds	HMIS Comparable Bed Coverage Rate for VSP Beds
ES	376	81	81	0	81	100.00%
SH	0	0	0	0	0	NA
TH	177	0	0	0	0	NA
RRH	106	45	45	0	45	100.00%
PSH	385	0	0	0	0	NA
OPH	39	0	0	0	0	NA
Total	1,083	126	126	0	126	100.00%

2025 HDX Competition Report

2026 Competition Report

PA-506 - Reading/Berks Count

For HIC conducted in January/

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current 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	376	225	376	59.84%
SH	0	0	0	NA
TH	177	77	177	43.50%
RRH	106	106	106	100.00%
PSH	385	385	385	100.00%
OPH	39	39	39	100.00%
Total	1,083	832	1,083	76.82%

2025 HDX Competition Report

2026 Competition Report - HIC Summary

PA-506 - Reading/Berks County 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.

2025 HDX Competition Report

2026 Competition Report - PIT Summary

PA-506 - Reading/Berks County 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	453	433	420
Safe Haven Total	0	0	0
Transitional Housing Total	76	70	101
Total Sheltered Count	529	503	521
Total Unsheltered Count	232	179	213
Total Sheltered and Unsheltered Count*	761	682	734

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	54	47	63
Total Unsheltered Count	55	79	86
Total	109	126	149

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

**3A-1. HUD-2996 Certification for Opportunity
Zone Preference Points**

Documents include the following:

- **HUD-2996 completed by the Berks Coalition to End Homelessness (CoC Lead Agency) on behalf of CoC-funded projects**

**Certification for Opportunity Zones
Preference Points**

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

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

Type or clearly print the following information.

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

Applicant Organization: Berks Coalition to End Homelessness

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

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

14.267 -- Continuum of Care Program

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

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

42011011200
42011002500
42011000100
42011001300
42011000900

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

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

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

Estimated Funding Allocations

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

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

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

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

The funding provided to PA-506 CoC-funded programs will mainly benefit residents in the opportunity zones listed above. The projects provide rental assistance, permanent housing, and supportive services to people experiencing homelessness. When people experiencing homelessness are provided housing and services, the areas they previously congregated (parks, main thoroughfare, etc.) are cleaner and safer, thus improving the overall community. Improving the community in this way will encourage business and developers to invest in the area more.

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

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

Certification of Authorized Representative for the Applicant:

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

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

Prefix: First Name: Middle Name:

Last Name: Suffix:

Title:

Organization:

Signature:

Date:

FY 2026

PA-506 - Reading/Berks County

Continuum of Care

**3A-DP. Your CoC's Policy or Statement to
Advance Recovery**

Documents include the following:

- **Expert from the PA-506 Written Standards stating that all CoC-funded housing projects must:**
 - **Prohibit the operation of drug injection sites, “safe consumption sites,” or any facilities facilitating illicit drug use.**
 - **Prohibit the distribution, or use of illicit drugs or drug paraphernalia on or off property under their control.**
 - **Prohibit conducting, permitting, encouraging, or allowing any of the above activities under the pretext of “harm reduction.”**

CoC Drug Free Housing

All CoC-funded housing projects must operate in compliance with federal regulations (24 CFR 578) and align with the CoC's commitment to providing safe, drug-free housing environments.

All CoC-funded housing projects must:

- Prohibit the operation of drug injection sites, "safe consumption sites," or any facilities facilitating illicit drug use.
- Prohibit the distribution, or use of illicit drugs or drug paraphernalia on or off property under their control.
- Prohibit conducting, permitting, encouraging, or allowing any of the above activities under the pretext of "harm reduction."

Projects may not require participants to be sober or participate in treatment to receive assistance, or evict or exit participants for a first-time violation of a drug-related program policy or lease requirement, unless otherwise required by law or project-specific policies.

As with other policies in the CoC Written Standards, if a CoC-funded housing project is found to be in violation of this policy, the CoC will consider the violation a "finding" for the annual CoC monitoring. Monitoring results are provided to the funding committee for the CoC Program competition, and are considered when prioritizing projects.

Record Retention

All records pertaining to Continuum of Care funds must be retained for the greater of 5 years or the period specified below. Copies may be substituted for the original records.

Per 24 CFR 578.103(c)(1), documentation of each program participants' qualifications, eligibility documentation, and other program participant records must be retained for 5 years after the expenditure of all funds from the grant under which the program participant was served.

Where CoC funds are used for the acquisition, new construction, or rehabilitation of a project site, records must be retained until 15 years after the date that the project site is first occupied or used by project participants.

Following the required record retention period, organizations must dispose of all documents and files in a manner that will protect client confidentiality. Methods include:

- Shredding applicable paper records
- Deleting any information from computers and destroying the files before disposal
- Triple formatting hard drives of any machine before transfer of property and/or destruction of hard drives of any machine that has contained client records before disposal.