

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: NJ-509 - Morris County CoC

1A-2. Collaborative Applicant Name: County of Morris

1A-3. CoC Designation: CA

1A-4. HMIS Lead: NJ DCA

1B. Coordination and Engagement–Accountable Structure and Participation

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

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- Frequently Asked Questions

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

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

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

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

17.	State Government Staff/Official(s)	Yes	
18.	State or Local Elected Public Official(s)	Yes	
19.	Local Jail(s)	Yes	
20.	Mental Health Service Organization(s)	Yes	
21.	Mental Illness Advocate(s)	Yes	
22.	Organization(s) led by and serving people with disabilities	Yes	
23.	Other homeless subpopulation advocate(s)	Yes	
24.	Other nonprofit homeless assistance provider(s)	Yes	
25.	Other social service provider(s)	Yes	
26.	Public Housing Agencies	Yes	
27.	Recovery Housing or Sober Living Provider(s)	Yes	
28.	School Administrators/Homeless Liaison(s)	Yes	
29.	School District(s)	Yes	
30.	Street Outreach Team(s)	Yes	
31.	Substance Abuse Advocate(s)	Yes	
32.	Substance Abuse Service Organization(s)	Yes	
33.	Universities	Yes	
34.	Veteran Serving Organization(s)	Yes	
35.	Agencies Serving Survivors of Human Trafficking	Yes	
36.	Victim Service Provider(s)	Yes	
37.	Domestic Violence Advocate(s)	Yes	
38.	Other Victim Service Organization(s)	Yes	
39.	State Domestic Violence Coalition	Yes	
40.	State Sexual Assault Coalition	Yes	
41.	Youth Advocate(s)	Yes	
42.	Youth Homeless Organization(s)	Yes	
43.	Youth Service Provider(s)	Yes	
44.	Other Homeless Assistance Provider(s)	Yes	
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	
	Other: (limit 50 characters)		
46.			
47.			

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

(limit 2,500 characters)

The CoC full membership and sub-committee meetings are open to all interested persons or entities and dates, descriptions, and locations for all CoC meetings and Executive Committee meetings are publicly posted on the Morris County (CoC Lead) website as part of a calendar with many other community events appealing to community members. Anyone interested in participating can enter their individual/agency information into an e-form to submit an application for membership even prior to attending a CoC meeting. CoC Community Assistance Service meetings are in-person. CoC membership information and meeting notices are sent out via email in accessible digital formats to ensure compatibility with text to speech programs & conversion to large text for individuals with disabilities or in need of accommodations. Information on joining the CoC is also available on the CoC website, which is also compatible with these accessible digital tools and is instantly translatable for prospective members who are not fluent in English. Emails are sent to a variety of listservs to expand the number of agencies/advocates aware of the CoC process. The Executive Committee routinely examines membership and actively works to solicit participation from sectors insufficiently represented in the CoC membership (at both full membership and executive membership level).

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)

The strategy to solicit & consider opinions from many entities is to incorporate them into CoC membership and invite them to meetings and trainings on topics related to those experiencing homelessness, which may intersect with other professional disciplines. The CoC's Executive Committee (EC) members currently include: hospitals, shelter & housing providers, food insecurity programs, formerly homeless individuals, DV advocates, childcare providers, veteran service providers, faith-based organizations, mainstream benefits/welfare agency providers, public housing authorities & mental health/substance use disorder service providers. Input on needs & strategies are generated through EC, full membership & subcommittee meetings, & having a broad representation among the membership is essential to creating holistic & effective strategies. Executive committee members are also represented on a number of associated groups and committees including Human Services Advisory Council, the county's PCC, Fair Housing Committee, and Hope Hub, which is an initiative through the County Sheriff's office to connect those at risk to services they need.

The CoC Lead, Morris County, is also a local Consolidated Plan Jurisdiction & regularly posts info for public comment pertaining to ESG, CDBG, HOME, & local funding sources, including solicitation of comments about how funds impact housing & homelessness. The CoC also communicates information at County Commissioner-appointed Homeless Advisory Committees.

Public input on preventing and ending homelessness is solicited both during virtual and in-person meetings, and also through email. Meeting notices are sent out via email in accessible electronic formats to ensure compatibility with text to speech programs & conversion to large text for individuals in need of accommodations. Emails are sent to a variety of listservs to expand the # of agencies/advocates aware of the CoC process. The County website is also compatible with these digital tools & is instantly translatable for prospective members who are not fluent in English.

The CoC actively considers info gathered from public comment & public meetings to make improvements in serving homeless persons. For instance: persons with lived expertise proposed and initiated massive changes to the local PIT planning and implementation. The CoC also actively solicited public comment on the strategic plan, written standards, Code Blue survey, and other CoC-wide policies

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.
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(limit 2,500 characters)

In June 2026 the CoC announced its Request for Proposals (RFP) on the CoC website, local newspaper, at human services related meetings & mass emails through Human Service & CoC listservs using accessible digital formats to ensure compatibility with text to speech programs & conversion to large text for individuals with disabilities. The RFP for new & renewal project applications stated "projects may apply for new funding that may be made available through reallocation of existing monies or new bonus funding, & applicants who have not previously received CoC funding are encouraged to apply."

The CoC RFP announcement included instructions to submit applications via the SurveyMonkey Apply platform, the RFP application questions, scoring rubric, & CoC funding priorities. The RFP identified requirements for applicants. A technical assistance (TA) session open to any interested new or renewal applicants was held on 6/17/26 to provide a full scope of the CoC process, funding eligibility requirements, priorities, and submission instructions.

The CoC RFP and TA session explained that during the review process, new projects are scored and ranked based on the percentage of points awarded from the new project scoring rubric enabling cross comparison & ranking w/ renewal projects.

All local competition notices were sent out via email in accessible digital formats to ensure compatibility with text to speech programs & conversion to large text for individuals in need of accommodations. Competition announcements were mentioned at virtual meetings and notices were posted on the Morris County website which is also compatible with these digital tools as well as being instantly translatable for prospective members who are not fluent in English.

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

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

(limit 2,500 characters)

The CoC Executive Committee annually evaluates the strategic goals of the previous year and sets targeted goals for the upcoming year. The Executive committee evaluates the current subcommittee goals and updates or determines new strategies for the coming year and if new work groups need to be developed. The CoC also developed a data strategic plan in 2025 and the data subcommittee is responsible for overseeing the implementation of the strategies from the plan. The other subcommittees include the coordinated assessment committee and community assistance services committee. They remain responsible to ensure the strategies developed by the Executive Committee are implemented.

1B-5a Confirmation of Plan Coverage.

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

1. Identifies the gap, using data or stakeholder feedback

Yes

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

1C. Coordination and Engagement

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	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?	71%

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

(limit 2,500 characters)

n/a

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

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

(limit 2,500 characters)

New Hope Integrated Behavioral Healthcare is a statewide agency dedicated to the treatment of adults and youth affected with substance abuse issues. The agency provides all levels of recovery services from inpatient, long term substance abuse treatment to outpatient services. New Hope is a key partner with all hospital systems in receiving referrals from social workers/case managers that come into the hospital to detox from substance and then are referred to New Hope for long term care; referral sources also include advocates, family members, and self referral. The agency works closely with community based agencies, including housing agencies affiliated with the CoC to get consent forms signed so that care coordination is happening throughout the patient's treatment. New Hope works to refer patients with housing needs to step down sober living homes or transitional housing in the community they were referred from. New Hope staff, sober living house managers, and community based agencies coordinate care to ensure the person is working on building life skills, building a resume, and working towards employment during the sober living transition. Any necessary community based referrals and linkage happens at that time including linkage to sobriety supports (AA/NA), outpatient behavioral health counseling, case management, medication management.

1C-1b. Treatment and Recovery Services—Peer Support and Recovery Navigation.

Describe how your CoC partners with, or has projects that provide access to, peer recovery specialists or other forms of peer support and recovery navigation.

(limit 2,500 characters)

Prevention is Key (PIK) is a CoC member and a partner with Morris County DHS, CoC Lead. PIK works to support persons with active substance abuse issues in the community to get the resources they need to sustain sobriety. PIK has a center for addiction recovery education and success center that provides support in assisting people to move from dependency on substances to interdependency, build or repair community supports, provide coaching and training to help people achieve independence. Operation Helping Hand (OOH) is a program PIK has in partnership with the prosecutor's office to provide support and case management to individuals that have been arrested for possessory drug offenses. PIK also has a mobile recover vehicle, Hope One, to provide in community supports to those struggling with substance abuse to help them connect with treatment and recovery services.

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 works closely with community based mental health provider (CMHP), St Clare's, in identifying the housing needs of persons with serious mental illness (SMI). The ST Clare's has community support services (CSS) that provides intensive case management to those with SMI. The CSS program has a connection to NJ Division of Mental Health and Addiction Services (DMHAS) which has statewide rental assistance vouchers that are specifically accessible to program participants in CSS. The CSS team provides intensive case management, case coordination with probation officers, intensive outpatient programs, medically assisted treatment programs, and linkage to ongoing community resources. St Clare's also has a PATH and PACT team that provide intensive case management in the community and connect client's to community resources such as social services: SNAP, Medicaid.

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 Assisted Outpatient Treatment and CSS program through St Clare's work with the hospitals and courts to ensure persons in the program have safe, stable housing with intensive supports in the community. The Mental Health Association also has the STAR, successful transition and re-entry program, that works collaboratively with St Clare's to ensure there are warm hand offs to community based providers when individuals leave correctional facilities.

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)

Mental Health Association and St Clare's are CoC members, MHA is even a CoC funded agency. The agencies attend CoC meetings and know the coordinated entry referral process and work collaborative with CE to refer any clients that are experiencing homelessness. MHA and St Clare's have access to specific vouchers through the state from DMHAS. Although they may not need a voucher the client's are still connected to coordinated entry and are referred to any other housing services they may need: utility assistance, security deposit, prevention (if ongoing voucher is not needed).

MHA and St Clare's both have CSS programs that provide the intensive in community case management to clients. CSS mandates clients are working towards targeted, achievable goals and receive the community supports they need to build those independent skills to maintain their housing with the least restrictive services necessary in place.

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)

Morris CoC has a Psychiatric Emergency Screening Services (PESS) provider, St Clare's, that is responsible for responding and evaluating community members in mental health crisis. The PESS provider responds with emergency services or law enforcement agencies to community locations to evaluate persons for safety and resource referral. If the person is a danger to themselves or others they will be brought to a local ED to be evaluated for voluntary or involuntary hospitalization. If the person is n

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)

St Clare's is a community mental health center and provides early intervention support services, peer wellness centers, outpatient mental health treatment through peer support, counseling, and psychiatry. The Center for Family Guidance has a crisis stabilization center in the community.

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)

Milestone House operates sober housing and is supported in the FY2026 process for the Milestone House Recovery and Housing Stability Initiative transitional housing project with 20 beds.

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 member agency Prevention is Key (PIK) recovery center in Morris County operates a day center and has a patient navigator in the community working to strengthen relationships with housing service providers in the community. The PIK agency also offers daytime respite services to allow unhoused persons somewhere to do laundry, shower, and receive recovery support. PIK is able to provide referrals to coordinated entry and other housing resource referrals to anyone that comes into the respite center. St Clare's and MHA are both CoC members that attend bi monthly CoC and subcommittee meetings. The coordinated entry committee meets bimonthly and all partners are encouraged to attend case conferencing to ensure client's on the prioritization list have all the necessary in community supports they need to work towards housing stability.

1C-2.	Supportive Services Investment.	
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	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$2,229,722
2. Of projects your CoC proposed to be funded in the FY 2026 CoC Program Competition, enter the total amount of funding for the supportive services budget line items.	\$1,136,799
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	51%
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.	

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).	51%
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You must provide a response for elements 1, 2
and 4 in question 1C-2.

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)?

You must provide a response in question 1C-3.

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)

There are 2 ESG recipients in the region: Morris County (MC) & the State of NJ. The CoC Executive Committee (EC) approves performance standards & the ESG recipient considers CoC funding priorities in their allocation process. The MC ESG recipient is a member of the CoC EC & participates in all CoC meetings. The CoC EC chair serves on the Morris County Human Services Advisory Council & serves by participating in ESG program review & funding meetings. The MC ESG recipient shares funding recommendations with the CoC EC & presents ConPlan updates/action plans for public comment at CoC full membership meetings.

To better coordinate non-CoC resources, the CoC recently created a funding matrix of all funding going through the community.

NJDCA hosts a public comment conference call after they have developed their funding priority recommendations for ESG funds annually. The CoC participated in the CoC meeting to provide feedback about the best ways to target ESG funding. All projects requesting funding through NJDCA ESG process must obtain a letter of support from the CoC. The CoC EC reviews all proposals requesting funding through the NJDCA ESG program & issues letters of support to those projects that are in line with local funding priorities & demonstrate an ability to work with the CoC in ending homelessness. The CoC EC also participated in specialized conference calls with NJDCA re: ESG RRH program, ensuring the RRH program utilized the local coordinated entry process.

In addition, the staff of MC provide staffing for conducting the monitoring for both ESG & CoC-funded projects. The CoC PIT & HIC information, as well as strategic plans, gaps & needs, are shared with the ConPlan jurisdiction for inclusion in their plan. The CoC data standards also ensure all CoC and ESG agencies are contributing to the overall data quality for PIT and HIC.

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

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

(limit 2,500 characters)

The shelter providers, Homeless Solutions, Rescue Mission, and Family Promise are all members of the CoC. They work directly with coordinated entry to refer all clients who have not been assessed and added to the prioritization list. The shelter providers participate in case conferencing to ensure all relevant and updated information is shared with the Coordinated entry agency, CSPNJ. The shelters also work with all individuals and families to connect them to the office of temporary assistance to get connected with Medicaid, SNAP, TANF, general assistance.

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 Morris County CoC Lead is Morris County Dept of Human Services, and also serves as a point in time coordinator for the community. The CoC shares the PIT data with local offices of emergency management to ensure proper planning for all seasonal shelter needs: Code Blue and Code Red. SPM and other system level data trends are assessed and brought to the attention of the executive committee by the CoC Lead to ensure proper system planning and strategic program implementation can respond to community needs. CoC governance allows for comprehensive data sharing as long as it does not include PII. The PIT data is also shared with the county and municipal government community development offices for inclusion in their consolidated plans for ESG, CDBG and HOME funding.

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 coordinates data sharing with the hospital systems, mental health providers, and division of mental health and addiction services to ensure that the supports needed to assist persons experiencing homelessness are available in the community to help transition to stable housing situations. The CAS, Community Assistance Supports committee, meets bimonthly and shares information on trends being seen in the community that directly relate, or could impact, the housing and homeless service system. If needed smaller work groups are developed to do further data collection, both qualitative and quantitative, and will develop strategies to address these issues.

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)

All CoC providers refer to the County One-Stop Center/local Workforce Investment Board to help clients maintain eligibility for WorkFirst NJ TANF/General Assistance & achieve employment by accessing employment & training programs. The CoC has access to Support Team for Addiction Recovery (STAR) specialists who ensure persons exiting the criminal justice system that exit to homeless destinations are prepared for employment upon exit. CoC agencies also work with other partners to offer workshops on financial assistance & employment services. Homeless Solutions & Jersey Battered Women's Services both have partnerships with multiple private business employers in finance, communications, & other sectors to assist their program participants with job skills, readiness, mock interviews, & employment opportunities. A major step has been the advocacy of the CoC's Child Care Working Group. This group partnered with a statewide coalition to move NJ lawmakers to pass a measure ensuring homeless households receive presumptive eligibility for childcare subsidy programs, giving homeless families greater flexibility to increase employment income with childcare support. Additionally, the CoC Strategic Planning Committee developed the following goal that is directly aimed at increasing earned income: increasing capacity of housing and service providers to work with clients to increase earned cash income through the use of data, national best practices, and local resources.

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 Mental Health Association (MHA) currently conducts the primary outreach for the CoC. MHA works with human services organizations, police & hospitals to identify & outreach the most vulnerable & resistant. MHA receives daily referrals for those struggling to engage in housing services due to barriers like mental health, & outreaches by phone, email & in person. MHA outreaches referrals for at least 45 days but often longer. MHA trains staff annually in outreach foundations, behavioral health & national best practices on trauma informed approaches. MHA offers everyday support like hygiene items, food, clothing & services to improve quality of life. Additionally MHA conducts annual satisfaction surveys for agencies and consumers. If shelter/services are refused, connection and referrals will still be made to coordinated entry (CE) and other needed entities; clients will be prioritized for permanent housing opportunities

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)

Morris County Dept of Human Services, behavioral health, and substance abuse treatment, providers work with families and support networks to coordinate discharge planning to ensure the individual leaving treatment has safe, secure housing; as well as the proper familial and community supports to ensure ongoing sobriety and treatment are effective. New Hope, PIK, and MHA all have flexible funding sources to assist with in and out of state transportation, moving or relocation costs, and other special assistance needed to coordinate stable discharges.

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 supported two new street outreach programs in the FY2026 cycle through Family Promise of Morris County and Collaborative Support Programs of NJ. Both programs have history of collaborating and working with law enforcement to connect people experiencing homelessness to housing and supports in the community. Both agencies have indicated that they will cooperate, assist and not interfere or impede with law enforcement to enforce local laws and will assist first responders in engaging homeless individuals. CSPNJ will accept referrals from police departments. FPMC has a formal partnership with the Director of Public Safety for the Township of Morristown and the Morristown Police Chief, who serve as active operational partners in FPMC's street outreach model.

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)

Morris County CoC has two County funded outreach programs that are able to mobilized once an encampment is identified. The County's Navigating Hope (NH) & Hope One (H1) programs also bring services & connection to benefits through mobile outreach. The NH mobile van travels to hotspot areas like motels, encampments, & treatment clinics, to meet individuals where they are, & helps consumers apply for benefits & connect to social services. NH has been deployed at the local court so persons facing evictions can instantly access the homeless service system if necessary. H1, which operates similarly to NH, specializes in support services, specifically mental health services, for those struggling with addiction; if outreach workers are notified that persons experiencing homelessness are engaging in high-risk behavior, ie drug use, the county deploys the H1 van, which includes a consortium of providers, like a Support Team for Addiction Recovery (STAR) specialist & outreach worker. These providers meet weekly to ensure all persons in need have access to the system. Visions & Pathways also conducts street outreach for youth in the CoC to connect them with CE & services.

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)

The CoC has seen a significant reduction in encampments from 2025 to 2026. Through the point in time process in 2025 the CoC specifically collected information on the whether persons experiencing unsheltered homelessness were camping within the geographic area. In 2025 two encampments with 9 people were identified. In 2026 there was a reduction to 1 encampment with 2 people. The mobile outreach efforts and new coordinated entry provider and system implementation are credited with this reduction.

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 is supporting two new street outreach programs through FPMC and CSPNJ in the FY2026 cycle, both agencies work collaboratively with law enforcement in other programs in the community, and statewide. CSPNJ is the coordinated entry lead agency for the community and conducts street outreach statewide. CSPNJ has a grant in which they work and provide outreach to public transit centers at the request of the transit authority when anyone experiencing homelessness is in a public space. CSPNJ as the coordinated entry lead and CoC member will refer individuals experiencing homelessness to local resources: shelter, substance abuse treatment, mental health treatment, and housing resources. The CoC continues to partner with social service agencies and law enforcement to develop collaborative programs to reduce the burden of response from law enforcement and strengthen the connection to housing and treatment resources.

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)

The CoC does not have access to that data.

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)

New Jersey policies allow for emergency screening and intervention when an individual may be a danger to self or others, with an emphasis on providing care in the least restrictive appropriate setting. Mobile crisis response, crisis screening, and coordination among behavioral health providers, law enforcement, hospitals, and homeless-service providers in our CoC support these efforts.

The County's (PESS) program provides evaluations 24 hours a day, 365 days a year to individuals experiencing a psychiatric crisis or posing a danger to self, others, or property, prioritizing community-based stabilization over hospitalization whenever clinically appropriate. This structure gives CoC outreach staff and law enforcement a single, always-available clinical resource to refer individuals in crisis to for evaluation, ensuring involuntary commitment decisions are made by qualified screeners rather than by first responders alone, supporting both public safety and the individual's access to the least restrictive appropriate level of care.

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)

New Jersey's Megan's Law governs sex offender registration and community notification, restricting public disclosure of registrant information except through law enforcement's Megan's Law liaison process, particularly for Tier 3 (and select Tier 2) offenders. A subsequent statutory amendment further authorizes the Department of Human Services and county and municipal welfare agencies to access the state's sex offender registry specifically when placing homeless or displaced families into emergency shelter, including hotel and motel placements. This gives the County Board of Social Services and CoC providers a lawful pathway to check registry information before placing families in emergency shelter, while general registry information sharing for other CoC purposes continues to run through coordination with municipal police departments' Megan's Law liaisons rather than independent CoC access.

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)

Collaborative Support Programs of NJ (CSPNJ) is the primary street outreach provider in the CoC's region. CSPNJ conducts outreach through a number of programs including as the coordinated entry lead for Morris County CoC. CSPNJ also conducts statewide outreach through a contract with NJ transit in which they respond to public transit areas to conduct outreach and service connection to people in bus or train stations.

The County's Navigating Hope (NH) & Hope One (H1) programs also bring services & connection to benefits through mobile outreach. The NH mobile van travels to hotspot areas like motels, encampments, & treatment clinics, to meet individuals where they are, & helps consumers apply for benefits & connect to social services. NH has been deployed at the local court so persons facing evictions can instantly access the homeless service system if necessary. H1, which operates similarly to NH, specializes in support services, specifically mental health services, for those struggling with addiction; if outreach workers are notified that persons experiencing homelessness are engaging in high-risk behavior, ie drug use, the county deploys the H1 van, which includes a consortium of providers, like a Support Team for Addiction Recovery (STAR) specialist & outreach worker. These providers meet weekly to ensure all persons in need have access to the system. Visions & Pathways also conducts street outreach for youth in the CoC to connect them with CE & services. There are currently 2 CE Drop-In Centers that connect unsheltered households to mainstream benefits, services, & shelter and by 2025 it will be 3 drop-in centers along with increased mobile outreach through CE. MHA & the drop-in centers connect people to GA, TANF & SSI. Outreach services are well advertised at all County events. The CoC has held resource fairs to further outreach municipal leaders, schools, & libraries

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

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

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

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

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

(limit 2,500 characters)

All providers complete household assessments when families enroll in their programs. As part of the assessments, providers review current connections to school and other education related services for the household. Case managers work with households to identify if additional services are needed and provide support in helping the household connect to services available through the school system or community agencies. Additionally, youth advocate policies and procedures mandate training for providers who serve youth (0-24) to have training on McKinney Vento and navigating the school system. These trainings were provided and recorded by the CoC.

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 New Jersey Division of Children and Families (DCF) has local child welfare offices situated within each county in the state. The local offices are directly connected with the CoCs through a dedicated staff designee, Resource Development Specialist (RDS). The RDS and the assigned child welfare worker will coordinate supports to assist in stabilizing households, specifically with youth transitioning out of foster/public welfare placements, with access to permanent housing.

The Foster Youth Initiative program provides youth with long term housing vouchers and DCF has funded youth service providers statewide to provide housing navigation and supportive services to any youth in FYI or FUP vouchers. The NJDCF developed the Keeping Families Together program that provides long term case management and state rental assistance vouchers to families with children who have open child welfare cases and in need of housing supports, case management, linkage to substance abuse and recovery services.

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)

Visions & Pathways, the primary youth outreach provider in the region, is an active participant in the PIT planning process and coordinates with street outreach teams during the count. Visions and Pathways has worked with the CoC to identify ways to target youth. EDGE has also worked over the past year to increase available services in the CoC for homeless youth, efforts which have increased ongoing engagement with youth and improved PIT Count outreach practices.

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)

Jersey Battered Women Services, JBWS, is an agency that serves survivors of domestic violence and primarily serves families. JBWS is supported for two transitional housing programs in the FY2026 funding cycle.

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)

Upon entry into the program, each participant completes a comprehensive assessment to identify strengths, needs, barriers, and goals. Housing advocacy begins immediately and remains a priority throughout the participants' stay. During the first six months, participants work closely with staff to develop and implement an individualized service plan that may include counseling, safety planning, case management, referrals to community resources, and connections to services offered by JBWS, subrecipient agencies, and community partners through established MOUs.

Participants are encouraged to engage in services that align with their individualized service plans and support their long-term goals. Available services include workforce development, literacy and educational programming, financial literacy training, parenting education and coaching, job search assistance, employability skills development, resume preparation, and other supportive services that promote self-sufficiency.

Following the initial six months, participants meet with program staff at least every three months to review progress, reassess goals, and update service plans as needed. Ongoing participation in services that increase income, build skills, and enhance employability is required to remain in the program. Staff continue to connect participants with MOU partners and other community resources to ensure access to services that strengthen housing stability and support successful transitions to permanent housing.

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

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

(limit 2,500 characters)

The CoC has implemented a procedure where every household seeking assistance is connected to the available mainstream benefits programs. The CoC has partnered with Family Promise of Morris County (ES, TH, drop-in center) and with its Single Stop (SS) Program, which allows clients to be accurately screened & apply for benefits, so they can be quickly & effectively linked to cash & non-cash mainstream benefits from the county welfare agency (CWA). SS screening has effectively helped clients be awarded/confirmed for benefits including SNAP & MEDICAID totaling hundreds of thousands of dollars. Navigating Hope, a mobile van that travels throughout the County & helps community members apply for benefits & get connected to social services, has taken a significant amount of mainstream benefit applications. Hope Hub, a program with a consortium of providers, is managed by the Sheriff's office & allows for connection to benefits for community members at risk & in need of services. STAR (the CWA's jail re-entry program) is the direct benefits liaison for Hope Hub, so in addition to preventing recidivism in the jails through connection to benefits & social services, they work with the Hope Hub clients as well to connect to income.

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)

Child & Family Resources, Inc. (CFR), established in 1972, is a private nonprofit organization with extensive experience administering Federal, State, and County funds and providing services to children, families, and early childhood professionals. CFR is a partner with JBWS and is subrecipient on their TH grant. CFR currently serves as the Child Care Resource and Referral (CCR&R) agency for Morris County and maintains contracts with the New Jersey Department of Human Services, Division of Family Development (DFD), to administer and support programs funded through State and Federal resources. CFR also administers County funding through programs supported by the Morris County Grant-in-Aid program. The agency administers the Child Care Assistance Program (CCAP) in Morris County and supports other State, Federal, and County-funded initiatives designed to improve access to quality child care and strengthen services for children and families.

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)

Community Hope is both the SSVF provider and the BVH provider in the community. Community Hope provides prevention, emergency shelter, street outreach, and RRH/VASH for Veteran's experiencing homelessness.

** nbsp;**

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)

Jersey Battered Women's Services, JBWS, provides individualized services including safety planning, crisis intervention, counseling, legal advocacy, financial empowerment, life skills programming, workforce development, and connections to employment, healthcare, and permanent housing resources. Strong community partnerships further support coordinated service delivery and successful housing outcomes.

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)

Mental Health Association of Morris and Essex County STAR (Successful Transition and Re-Entry) program provides case management, medical care, recovery services, housing, employment assistance and connection to welfare benefits pre and post release from incarceration

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)

St Clare's, CSS and PACT programs all work with clients with high levels of medical needs.

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)

Welbe PACE, is a Program of All-Inclusive Care for the Elderly. It is a Medicaid/Medicare program designed to help older adults get the care that they need in their homes/community. A PACE care team is made up of an 11-discipline interdisciplinary team provides you and your family with multiple layers of support that enable you to live at home, where you want to be, with services designed around your needs and personal goals. PACE is both the healthcare

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)

The Mental Health Association administers the Safe Haven 10 PSH project as it aligns with our goal of ending homelessness in Morris County.

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

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

(limit 2,500 characters)

The Mental Health Association leverages supportive services through the Community Support Services (CSS) program to provide intensive case management to the ten permanent supportive housing units through the Safe Haven program. CSS is a psychiatric rehabilitation program through MHA that empowers consumers and teaches independent living skills to allow them to remain housed independently in the community. The CSS program has proved to be a sustainable model for consumers in their long term goal to remain housed. Community Support Services (CSS) utilizes evidence-based practices to enhance the services offered such as motivational interviewing and illness management and recovery.

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)

1.MHA operates outreach programs (Integrated Case Management Services, PATH, Assisted Outpatient Treatment, Collaborative Justice Services) that meet individuals where they are to increase access to care. Staff in these programs provide clients with linkage and referral to necessary resources. MHA also operates a Suicide Prevention Program that provides evidenced based programming on suicide prevention and mental health awareness. MHA operates a substance use treatment program that provides outpatient and intensive outpatient programming; medication management is available on an as needed basis. MHA provides outpatient therapeutic services providing individual therapy to adults. MHA has the PATH program which provides initial outreach, linkages and psychoeducation about the services mentioned above. PATH also provides transportation resources to ensure services like these are accessible. The staff that work in all of these programs have extensive training in counseling, de-escalation, and psychiatric assessments so they are able, in real time, to assess people exhibiting mental health symptoms for safety and determine if referral to PESS is needed.

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)

MHA continually assesses the service needs of clients through the quarterly treatment plan updates required by the CSS program model. Those that have made significant progress on goals and that are able to maintain independence but that just need fiscal support are referred to the CoC partners. MHA in partnership with the CoC has worked with all of the County PHAs. Specifically with Morris County (MCPHA), Dover (DPHA) and Madison (MPHA) PHAs. Our partnerships center around understanding barriers to housing, landlord programs, & prioritizing homeless households through preference & set asides. Once the TBRA vouchers under MCPHA expire, clients automatically move into permanent HCVs. Prioritized households are referred by shelter, outreach, and other partners using HMIS & Coordinated Entry.

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.	
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You must enter a date in question 1D-2a.

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.	
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You must enter a date in question 1D-2b.

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.	
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	

You must select a response for element 1 or 3— if you select Yes, you must enter a date in element 2 in question 1D-2d.

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.	08/04/2026
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1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
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	Describe:	
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,	

2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

1. Projects may be reallocated if they (1) voluntarily elect to have their project decreased or eliminated or (2) are not meeting local performance standards, are not in line with established community need, &/or have consistently unaddressed monitoring findings. The annual monitoring identifies areas where projects may be non-compliant with CoC & HUD requirements, including but not limited to: participation in coordinated entry, sufficient expenditure and appropriate use of funds, meeting reporting requirements, completion of staff training, & achieving positive housing & service outcomes for program participants. These data points are used to inform the CoC's determination about which projects are underperforming or being underutilized due to low community need for the project. The CoC's Local Selection Process Policy establishes objective scoring criteria that are used to make funding recommendations based on the CoC's established project priorities, project monitoring results, & project performance. The CoC's Allocations Committee reviews project monitoring findings for both fiscal & operational compliance as well as project utilization & outcome performance & determines whether projects are needed or are low-performing and should be reallocated.

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)	Foothold
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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.	Multiple CoCs
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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)

The PIT Count changes in methodology included:

- return of Project Homeless Connect events
- 7-day outreach and service-based count
- Reduction in use of volunteers to support the unsheltered count
- Increased connection with community-based services providers such as day centers, soup kitchens and medical facilities to identify and connect with unsheltered persons

The following safety measures were implemented:

- decrease face-to-face interactions with clients;
- decrease the number of volunteers who would need to work in physical proximity;
- provide of PPE to all volunteers; and
- design a process that minimizes close contact.

The CoC saw a 15% decrease in the PIT count; 75 person decrease for sheltered and 32 person decrease for unsheltered.

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

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

(limit 2,500 characters)

The CoC strategically operationalized street outreach to reduce encampments between 2025 and 2026. Morris County Sherriff Depot's Hope One Initiative where an outreach staff from MHA co-responds with law enforcement to hot spots where reported camps are seen. MHA also does regular canvassing along with CSPNJ the other Main Street outreach provider offering housing navigation along with other providers has shown effective in quickly moving individuals off the street into an appropriate placement.

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.	2
2. Enter the reduction in the number of encampments during your evaluation period.	1

2A-4b.	Reduce Encampments—Number of People in Encampments.	
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1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	9
2. Enter the reduction in the number of people in encampments during your evaluation period.	2

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)

NA there has been a reduction in encampments by one and by 7 persons.

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 has a separate prevention committee and maintains a prevention list for those who are at-risk of homelessness; the committee includes diversion and prevention providers and works together to address barriers for at-risk households. To prevent FTH, those at-risk and connected to CE are offered diversion assistance but then assessed and prioritized for connection to the Office of Temporary Assistance (OTA), the welfare and prevention agency. OTA provides prevention assistance or referral. CoC agencies coordinate to provide prevention services & ensure all agencies are aware of the system resources to direct clients properly. Sheltering agencies complete a diversion process where short term phone and in-person case management services are offered with a focus on repairing relationships & providing donated in-kind items. The coordinated entry with assessment & referral completed by the CE provider is continually working to streamline access to prevention services.

The CE leadership team reviews trends on reasons for homelessness quarterly & recommends strategies accordingly. Additionally, the CoC Strategic Planning Committee included the following goal in the 2024 Strategic Plan that is directly aimed at reducing the number of first time homeless: Enhancing eviction prevention and shelter diversion interventions; specifically leveraging resources and increasing community collaboration to engage households in sustainable housing solutions. The specific strategies used are: (1) Examine HUD/CoC Policies and (2) Inventory Required Trainings for CoC; (3) Outreach training providers to schedule and plan trainings; and (4) Provide trainings to full CoC.

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 Coordinated Entry (CE) allows for assessment & prioritization of the hardest-to-serve clients & facilitates quick exits to housing for those with the longest length of time homeless (LOT). Case conferencing and the prioritization list being viewable in HMIS ensures the long-staying homeless persons are targeted through a collaborative effort. The CoC also prioritized funding a new CE project by a provider that has demonstrated success connecting with & gaining the trust of the most vulnerable. . Additionally the CoC local selection and monitoring evaluate if CoC projects are low barrier to entry so those with highest barriers & longest LOT are prioritized for assistance.

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?	
---	--

You must enter a response for question 2A-7.

Describe how you calculated the data for this response.

(limit 2,500 characters)

To calculate this measure, HMIS data were reviewed for clients who exited Transitional Housing (TH), Rapid Re-Housing (RRH), or Permanent Supportive Housing (PSH). HMIS Reportbuilders were run for TIME PERIOD. The combined file was limited to records with an HMIS Project Type of Transitional Housing, PH – Rapid Re-Housing, or PH – Permanent Supportive Housing; all other project types were excluded. Because the reports include everyone enrolled during the period, records were then filtered by Discharge Date so that only exits occurring within the reporting period were counted.

Exits were then filtered using the HMIS Destination field to identify exits to the following unsubsidized permanent housing destinations:

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

Pivot tables were used to count qualifying exits for each destination, grouped by CoC and project type. The four destination totals were summed to produce the numerator. The denominator was the total number of TH, RRH, and PSH exits during the period to any destination. The measure was calculated by dividing the numerator by the denominator, producing the percent of program participants exiting TH, RRH, and PSH collectively 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.	01/27/2026
--	---	------------

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
--	--	-----

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

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

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

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

2A-9.	HMIS and Comparable Database Participation—Bed Coverage Rate.	
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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	362	30	375	96.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	91	34	125	100.00%
4. Rapid Re-Housing (RRH) beds	34	34	63	93.00%
5. Permanent Supportive Housing (PSH) beds	231	0	199	86.00%
6. Other Permanent Housing (OPH) beds	0	0	0	0.00%

2A-9a.	Partial Credit for Bed Coverage Rates of 84.99 Percent or Lower for Any Project Type in Question 2A-9.	
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For each project type with a bed coverage rate that is 84.99 percent or lower in question 2A-9, describe:

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

(limit 2,500 characters)

All project types have a bed coverage rate over 85%.

3A. Policy Initiatives

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

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

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

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

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

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

4A. Attachments Screen For All Application Questions

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

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

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

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

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

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

Attachment Details

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

Attachment Details

Document Description: 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment

Attachment Details

Document Description: 1C-3. Language from Project Supportive Service Agreements

Attachment Details

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

Attachment Details

Document Description: 1D-1. Local Competition Scoring Tool

Attachment Details

Document Description: 1D-2c. Local Competition Selection Results

Attachment Details

Document Description: 2A-8b. FY 2026 HDX Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: 3A-DP. 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	Please Complete
1D. Project Review/Ranking	Please Complete
2A. HMIS Implementation	Please Complete
3A. Policy Initiatives	09/28/2026
4A. Attachments Screen	09/28/2026
Submission Summary	No Input Required

1C-1

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

- 1) Edge New Jersey
 - a) Edge NJ PSH 1FY2026
 - b) Edge NJ PSH 2 FY2026
 - c) Transitional Housing
- 2) Department of Community Affairs FY2026 3AKNP CoC Renewal (PSH)
- 3) Mental Health Association PSH for Safe Haven

1C-1f

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

Tier	Rank	Score	Agency Name	Project Name	Program Type	Units	Units requiring substance use treatment
1	1	95.33%	EDGE New Jersey	EDGE NJ PSH 1 FY2026	PSH	6	6
1	2	91.78%	EDGE New Jersey	EDGE NJ PSH 2 FY2026	PSH	4	4
1	3	91.02%	Mental Health Association	PSH for Safe Haven FY2026	PSH	10	10
1	4	90.25%	Department of Community Affairs	FY2026 3AKNP CoC Renewal	PSH	18	18
1/2	7	88.70%	Family Promise of Morris County	Keys 2 Housing Consolidated	PSH	5	0
DV reallocation		86.75%	JBWS	JBWS Domestic Violence Transitional Grant	TH	6	0
2	8	96.44%	Family Promise of Morris County	FPMC Transitional Housing	TH	8	0
2	9	93.45%	EDGE New Jersey	Transitional Housing	TH	9	9
2	10	90.69%	The Milestone House	Milestone House Recovery and Housing Stability Initiative	TH	20	20
DV Bonus		86.42%	JBWS	JBWS Domestic Violence Transitional Living Program	TH	9	0

1C-3

Language from Project Supportive Service
Agreements

- 1) Edge
- 2) Family Promise of Morris County
- 3) JBWS
- 4) The Milestone House
- 5) Mental Health Association

EDGE NJ Service Participation Policy

I. Policy

The goal of Case Management Support Services is to promote and support independence and self-sufficiency of the individual to the fullest degree possible.

This policy is mandatory for all CoC funded housing programs.

II. Procedure

Case Management Support Services (SUPPORT SERVICES) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. SUPPORT SERVICES provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. SUPPORT SERVICES Services may also include assisting eligible members to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and Support Services, or private health care coverage plans. SUPPORT SERVICES Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

SUPPORT SERVICES Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

III. Key Service Components and Activities

1. Initial assessment of service needs
2. Development of a comprehensive, individualized care plan
3. Timely and coordinated access to medically appropriate levels of health, support services, and continuity of care.
4. Client-specific advocacy and/or review of utilization of services
5. Continuous client monitoring to assess the efficacy of the care plan
6. Re-evaluation of the care plan at least every 6 months with adaptations as necessary
7. Ongoing assessment of the client's and other key family members' needs and personal support systems
8. Assistance with enrollment in entitlement programs
9. Assistance in the acquisition of support services

IV. Service Limitations/Requirements

Clients receiving HUD/CoC funded housing services are required to participate in SUPPORT SERVICES and comply with all housing requirements.

V. Assessment and Service Plan

1. Individual/Family Comprehensive Needs Assessment

To identify the client's problems and care needs. The following information should be recorded and is required if a client does not have an active Medical Case Manager on file:

- a. Medical Care Provider
- b. Family History
- c. Exposure category
- d. Support systems
- e. Disclosure issues
- f. Nutritional screening
- g. Mental Health screening
- h. Substance Abuse screening
- i. Oral Health screening
- j. Educational/literacy assessment
- k. Living arrangements/Household size
- l. Identification of Legal Issues, if they exist
- m. Financial status to determine eligibility for entitlements
- n. Abuse, neglect and violence history

- o. Explanation of confidentiality and HIPAA requirements
- p. Explanation of the Grievance process
- q. Explanation of client's rights and responsibilities
- r. Explanation about the services available
- s. Signed consent for services
- t. Signed consent must have a date of activation and include a consent expiration date
- u. Current social needs
- v. Any additional information required by the CHAMP system not obtained at the intake

1. Development and Implementation of Service Plan:

The Service Plan should document long and short-term goals and objectives. It should be reviewed within 90 days and modified if necessary. Plan should include:

- a. Documentation of client participation in service decisions
- b. Goals and measurable objectives responding to client needs
- c. Timeframes to achieve objectives
- d. Screening for eligibility for entitlements and assistance in completing applications
- e. Ways to address barriers which are client specific
- f. Referrals for support services and documentation that appointments were kept
- g. Documentation of the client's participation in primary medical care.
- h. Notation of ongoing HIV education/counseling.
- i. Client signature and date, signifying agreement with Plan

2. Reassessment of Individualized Service Plan

A formal re-examination of the patient's condition, needs and resources to identify changes which occurred since the initial assessment or most recent assessment.

- a. Service Plan re-assessment and revision, if necessary, should be on-going for continuing members and within 90 days of initial assessment for new members
- b. Summary of progress in goal achievement should be documented
- c. Review of client's clinical, financial and support needs to identify changes and/or additional service needs o Case conference with other providers, when appropriate
- d. Bi-annual re-screening for Nutritional, mental health, oral health and substance use issues should be completed

3. Documentation

Written documentation is kept for each client, which includes:

- a. Documentation of need (e.g. bill or letter of termination) o Signed initial and updated individualized service plan
- b. Progress notes detailing each contact with or on behalf of the consumer. These notes should include date of contact and names of person providing the service
- c. Signed "Consent to release information" form. This form must be specific and time limited
- d. This shall comply with all required documentation from NEMA Universal Standards of Care

Family Promise of Morris County Consumer Service Participant Agreement

Housing Program Name: _____

Participant Name: _____

Participant Address (if applicable): _____

Program Case Manager/Representative: _____

Effective Date: _____

Term of Agreement: From _____ to _____

1. PURPOSE

This Service Participation Agreement ("Agreement") establishes the terms and conditions under which the Participant will receive services and assistance through the Housing Program ("Program"). The purpose of the Program is to provide housing-related support, resources, and services designed to assist Participants in achieving and maintaining stable housing.

This Agreement is not a lease, rental agreement, or property management contract unless otherwise specified in writing.

2. SERVICES PROVIDED

Subject to Program availability and eligibility requirements, the Program may provide one or more of the following services:

- Housing placement assistance
- Rental assistance or leased housing, if provided under the Participant's Program
- Case management services
- Financial literacy education
- Employment and benefits counseling
- Life skills training

- Referrals to healthcare, counseling, and community resources
- Tenant education and advocacy
- Other housing-related support services

The Program reserves the right to modify services based on funding, availability, or Participant needs.

3. PARTICIPANT RESPONSIBILITIES

The Participant agrees to:

A. Maintain Eligibility

- Provide accurate and complete information to Program staff.
- Notify the Program of any changes in income, household composition, employment status, contact information, or housing status within ten (10) business days.

B. Participate in Services

- Attend scheduled meetings, assessments, and appointments.
- Engage in service planning and goal-setting activities.
- Cooperate with Program staff in developing and implementing a housing stability plan.
- Take part in the services and activities listed in the Participant's individualized service plan. Participation in required services is a condition of continued assistance under the Program.
- • If enrolled in a Transitional Housing program, spend at least twenty (20) hours per week in services, activities, or employment, as set out in the Participant's service plan. Qualifying activities include case management, counseling, treatment, job search, job training, education, volunteering, community activities, and paid employment. This requirement does not apply to a Participant who is over age 62, an individual with handicaps as defined in 24 CFR 8.3, or a person with a developmental disability as defined in 24 CFR 578.3.
- • If a substance use need is identified through assessment or clinical evaluation, take part in the treatment recommended by the Participant's treatment provider. Participation in treatment is a condition of continued assistance under the Program.
- • Sign releases of information allowing Program staff to confirm attendance with treatment and service providers, as permitted by law.

C. Comply with Housing Requirements (if housing is provided under the Participant's Program)

Follow all applicable lease terms and property rules.

- Maintain the housing unit in a safe and sanitary manner.
- Avoid activities that may threaten the safety, well-being, or rights of others.

D. Financial Responsibilities

- Pay any required participant contributions, rent portions, utilities, or fees as required by the Program or housing provider.
- Provide documentation necessary to verify income and eligibility.

4. PROGRAM RESPONSIBILITIES

The Program agrees to:

- Treat Participants with dignity and respect.
 - Provide services in a professional and nondiscriminatory manner.
 - Maintain confidentiality of Participant information as permitted by law.
 - Inform Participants of available services, requirements, and any significant Program changes.
 - Respond to Participant questions and concerns in a timely manner.
-

5. CONFIDENTIALITY

Information collected by the Program will be kept confidential and used only for Program administration, service coordination, reporting requirements, and legal compliance, except as authorized by the Participant or required by law.

The Participant may be asked to sign separate consent forms authorizing the release of information to other service providers, landlords, or agencies.

6. NONDISCRIMINATION

The Program shall not discriminate against any applicant or Participant on the basis of race, color, religion, sex, national origin, disability, familial status, age, or any other characteristic protected under applicable federal, state, or local law.

7. GRIEVANCE PROCEDURE

Participants may submit complaints or grievances regarding Program services by:

1. Submitting a written complaint to the Program Representative.
2. Participating in a review meeting if requested.
3. Receiving a written response regarding the outcome of the review.

The filing of a grievance shall not result in retaliation.

8. TERMINATION OF PARTICIPATION

Program participation may be terminated for any of the following reasons:

- Failure to maintain Program eligibility.
- Repeated failure to participate in required services.
- Fraud, misrepresentation, or intentional withholding of information.
- Threatening, violent, or illegal behavior.
- Violation of Program policies.

The Program will provide written notice of termination and information regarding any appeal process via:

- a written copy of the rules before assistance begins
- written notice with the reasons for termination
- review by someone other than the person who made the decision (or their subordinate)
- prompt written notice of the final decision

Participants may voluntarily withdraw from the Program at any time by providing written notice.

9. LIMITATION OF SERVICES

The Program does not guarantee:

- Permanent housing placement.
- Approval for rental assistance.
- Continued funding availability.
- Employment, benefits, or specific housing outcomes.

Services are contingent upon available resources, eligibility, and Program requirements.

.

10. INDEMNIFICATION

To the extent permitted by law, the Participant agrees that the Program shall not be liable for losses, damages, injuries, or claims arising from the Participant's actions, omissions, or use of housing services, except where caused by the negligence or willful misconduct of the Program.

11. ACKNOWLEDGMENT

By signing below, the Participant acknowledges that:

- They have read and understand this Agreement.
 - They have had an opportunity to ask questions.
 - They agree to comply with Program requirements.
 - Enrolling in the Program is voluntary, and once enrolled, taking part in required services is a condition of continued assistance..
-

Participant Signature

Participant Name: _____

Signature: _____

Date: _____

Staff Representative Signature

Representative Name: _____

Title: _____

Signature: _____

Date: _____

EMERGENCY CONTACT (OPTIONAL)

Name: _____

Relationship: _____

Phone Number: _____

SERVICE PARTICIPATION AGREEMENT

Housing Program Name: _____

Participant Name: _____

Participant Address (if applicable): _____

Program Case Manager/Representative: _____

Effective Date: _____

Term of Agreement: From _____ to _____

1. PURPOSE

This Service Participation Agreement ("Agreement") establishes the terms and conditions under which the Participant will receive services and assistance through the Housing Program ("Program"). The purpose of the Program is to provide housing-related support, resources, and services designed to assist Participants in achieving and maintaining stable housing.

This Agreement is not a lease, rental agreement, or property management contract unless otherwise specified in writing.

2. SERVICES PROVIDED

Subject to Program availability and eligibility requirements, the Program may provide one or more of the following services:

- Housing placement assistance
- Rental assistance
- Case management services
- Financial literacy education

- Employment and benefits counseling
- Life skills training
- Referrals to healthcare, counseling, and community resources
- Tenant education and advocacy
- Other housing-related support services

The Program reserves the right to modify services based on funding, availability, or Participant needs.

3. PARTICIPANT RESPONSIBILITIES

The Participant agrees to:

A. Maintain Eligibility

- Provide accurate and complete information to Program staff.
- Notify the Program of any changes in income, household composition, employment status, contact information, or housing status within ten (10) business days.

B. Participate in Services

- Attend scheduled meetings, assessments, and appointments.
- Engage in service planning and goal-setting activities.
- Cooperate with Program staff in developing and implementing a housing stability plan.

C. Comply with Housing Requirements

- Follow all applicable lease terms and property rules.
- Maintain the housing unit in a safe and sanitary manner.
- Avoid activities that may threaten the safety, well-being, or rights of others.

D. Financial Responsibilities

- Pay any required participant contributions, rent portions, utilities, or fees as required by the Program or housing provider.
 - Provide documentation necessary to verify income and eligibility.
-

4. PROGRAM RESPONSIBILITIES

The Program agrees to:

- Treat Participants with dignity and respect.
 - Provide services in a professional and nondiscriminatory manner.
 - Maintain confidentiality of Participant information as permitted by law.
 - Inform Participants of available services, requirements, and any significant Program changes.
 - Respond to Participant questions and concerns in a timely manner.
-

5. CONFIDENTIALITY

Information collected by the Program will be kept confidential and used only for Program administration, service coordination, reporting requirements, and legal compliance, except as authorized by the Participant or required by law.

The Participant may be asked to sign separate consent forms authorizing the release of information to other service providers, landlords, or agencies.

6. NONDISCRIMINATION

The Program shall not discriminate based on race, color, religion, sex, gender identity, sexual orientation, national origin, age, disability, veteran status, marital status, or any other protected characteristic under applicable law.

7. GRIEVANCE PROCEDURE

Participants may submit complaints or grievances regarding Program services by:

1. Submitting a written complaint to the Program Representative.
2. Participating in a review meeting if requested.
3. Receiving a written response regarding the outcome of the review.

The filing of a grievance shall not result in retaliation.

8. TERMINATION OF PARTICIPATION

Program participation may be terminated for any of the following reasons:

- Failure to maintain Program eligibility.
- Repeated failure to participate in required services.
- Fraud, misrepresentation, or intentional withholding of information.
- Threatening, violent, or illegal behavior.
- Violation of Program policies.

When practicable, the Program will provide written notice of termination and information regarding any appeal process.

Participants may voluntarily withdraw from the Program at any time by providing written notice.

9. LIMITATION OF SERVICES

The Program does not guarantee:

- Permanent housing placement.
- Approval for rental assistance.
- Continued funding availability.
- Employment, benefits, or specific housing outcomes.

Services are contingent upon available resources, eligibility, and Program requirements.

10. INDEMNIFICATION

To the extent permitted by law, the Participant agrees that the Program shall not be liable for losses, damages, injuries, or claims arising from the Participant's actions, omissions, or use of housing services, except where caused by the negligence or willful misconduct of the Program.

11. ACKNOWLEDGMENT

By signing below, the Participant acknowledges that:

- They have read and understand this Agreement.
 - They have had an opportunity to ask questions.
 - They agree to comply with Program requirements.
 - They understand participation is voluntary and subject to Program policies.
-

PARTICIPANT SIGNATURE

Participant Name: _____

Signature: _____

Date: _____

PROGRAM REPRESENTATIVE

Representative Name: _____

Title: _____

Signature: _____

Date: _____

EMERGENCY CONTACT (OPTIONAL)

Name: _____

Relationship: _____

Phone Number: _____



THE MILESTONE HOUSE SERVICE PARTICIPATION AGREEMENT

Housing Program Name: Milestone House Recovery and Housing Stability Initiative

Participant Name: _____

Participant Address (if applicable):

Program Case Manager/Representative:

Effective Date: _____

Term of Agreement: From _____ to _____

1. PURPOSE

This Service Participation Agreement ("Agreement") establishes the terms and conditions under which the Participant will receive housing and supportive services through the Milestone House Recovery and Housing Stability Initiative ("Program"), operated by The Milestone House. The purpose of the Program is to provide structured, recovery-oriented Transitional Housing and supportive services designed to help Participants achieve stabilization, build recovery capital, and transition successfully to permanent housing. This Agreement is not a lease, rental agreement, or property management contract unless otherwise specified in writing.

2. SERVICES PROVIDED

Subject to Program availability and eligibility requirements, the Program may provide one or more of the following services:

- Transitional Housing
- Individualized case management and recovery planning



- Peer recovery support
- Housing readiness and permanent housing planning
- Employment and educational assistance
- Benefits navigation and enrollment assistance
- Financial capability and fiscal readiness support
- Life skills programming
- Transportation assistance
- Referrals to substance use treatment, mental health services, healthcare, and other community resources
- Other housing-related and recovery support services

The Milestone House reserves the right to modify services based on funding, availability, or Participant needs. The Program does not directly provide clinical substance use treatment; such services are accessed through referral to community treatment providers of the Participant's choosing.

3. PARTICIPANT RESPONSIBILITIES

The Participant agrees to:

A. Maintain Eligibility

- Provide accurate and complete information to Program staff.
- Notify the Program/The Milestone House of any changes in income, household composition, employment status, contact information, or housing status within ten (10) business days.

B. Participate in Services

- Attend scheduled meetings, assessments, and case management appointments.
- Engage in individualized recovery and housing planning and goal-setting activities.
- Cooperate with Program staff in developing and implementing an individualized recovery and housing plan.
- Maintain the level of engagement in services, activities, and/or employment required by the Program.

C. Comply with Program and Housing Requirements



- Follow all applicable Milestone House recovery residence policies and house rules.
- Maintain the housing unit in a safe and sanitary manner.
- Actively engage in clinically recommended outpatient substance use treatment and other behavioral healthcare as appropriate, and cooperate with Program staff in coordinating and monitoring that engagement.
- Avoid activities that may threaten the safety, well-being, or recovery of other residents.

D. Financial Responsibilities

- Pay any required participant contributions, rent portions, utilities, or fees as required by the Program.
- Provide documentation necessary to verify income and eligibility.

4. PARTICIPANT RESPONSIBILITIES

The Milestone House agrees to:

- Treat Participants with dignity and respect.
- Provide services in a professional, trauma-informed, and nondiscriminatory manner.
- Maintain confidentiality of Participant information as permitted by law.
- Inform Participants of available services, program requirements, and any significant Program changes.
- Respond to Participant questions and concerns in a timely manner.

5. CONFIDENTIALITY

Information collected by The Milestone House will be kept confidential and used only for Program administration, service coordination, reporting requirements (including HMIS reporting where applicable), and legal compliance, except as authorized by the Participant or required by law.

The Participant may be asked to sign separate consent forms or releases of information authorizing communication with treatment providers, landlords, or other agencies involved in the Participant's care.



6. NONDISCRIMINATION

The Program/The Milestone House shall not discriminate based on race, color, religion, sex, gender identity, sexual orientation, national origin, age, disability, veteran status, marital status, use of medication-assisted treatment (MAT), or any other protected characteristic under applicable law.

7. GRIEVANCE PROCEDURE

Participants may submit complaints or grievances regarding Program services by:

- Submitting a written complaint to the Program Coordinator.
- Participating in a review meeting if requested.
- Receiving a written response regarding the outcome of the review.

The filing of a grievance shall not result in retaliation.

8. TERMINATION OF PARTICIPATION

Program participation may be terminated for any of the following reasons:

- Failure to maintain Program eligibility.
- Repeated failure to participate in required services or clinically recommended treatment.
- Fraud, misrepresentation, or intentional withholding of information.
- Threatening, violent, or illegal behavior.
- Violation of Milestone House recovery residence policies.

When practicable, the Milestone House will provide written notice of termination and information regarding any appeal process. Participants may voluntarily withdraw from the Program at any time by providing written notice.



9. LIMITATION OF SERVICES

The Program does not guarantee:

- Permanent housing placement.
- Approval for rental or financial assistance.
- Continued funding availability.
- Employment, benefits, or specific housing or recovery outcomes.

Services are contingent upon available resources, eligibility, and Program requirements.

10. INDEMNIFICATION

To the extent permitted by law, the Participant agrees that the The Milestone House shall not be liable for losses, damages, injuries, or claims arising from the Participant's actions, omissions, or use of housing services, except where caused by the negligence or willful misconduct of the the Milestone House.

11. ACKNOWLEDGMENT

By signing below, the Participant acknowledges that:

- They have read and understand this Agreement.
- They have had an opportunity to ask questions.
- They agree to comply with Program requirements.
- They understand participation is voluntary and subject to Program policies.

PARTICIPANT SIGNATURE

Participant Name: _____

Signature: _____

Date: _____

PROGRAM REPRESENTATIVE



Representative Name: _____

Title: _____

Signature: _____

Date: _____

EMERGENCY CONTACT (OPTIONAL)

Name: _____

Relationship: _____

Phone Number: _____

MENTAL HEALTH ASSOCIATION OF ESSEX MORRIS, INC.
COMMUNITY SUPPORT SERVICES

80 Main Street, suite 370, West Orange, New Jersey 07052

Phone: 973-509-3777

Fax: 973-325-3079

300 Littleton Road, 3rd Floor, Parsippany, NJ 07054

Phone: 973-334-3496

Fax: 973-334-4920

CSS SERVICE AGREEMENT

Name:
sample sample

Date of Birth:
01/01/1950

SS#
000-00-0000

This is to acknowledge that Community Support Services (CSS) through the Mental Health Association of Essex and Morris, Inc. I understand these services are to assist me with my recovery goals, including but are not limited to achieving and maintaining a valued life role in the social, employment, physical health, education, and/or housing domains. These services include but are not limited to:

Recovery Management Services:

Recovery Management services are consumer-centered services provided predominantly in your natural environment. They are designed to work in a collaborative partnership with you by helping you gain access to needed medical, social, educational, vocational, recreational and other services and resources. The CSS staff, in partnership with you, will seek to identify the types of activities which would most help you maximize opportunities for successful community living.

Housing Search: CSS will assist you in locating housing opportunities, negotiating with landlords, saving for or obtaining security deposits, furnishing the home, accessing household supplies, moving in and on-going advocacy with landlord/property manager.

Moving In: CSS will assist you in setting up utility accounts and identifying natural supports to develop and carry out a move-in plan.

Landlord/neighbor relationship: CSS will educate you on your rights and obligations as tenants/neighbors as well as fair housing laws and landlord-tenant laws.

Comprehensive Rehabilitative Needs Assessment: CSS will collaborate with you to develop a comprehensive rehabilitative needs assessment where your strengths, needs, and preferences in various areas will be outlined.

Individualized Rehabilitation Plan: The individualized rehabilitation plan, based on the comprehensive rehabilitative needs assessment, will be developed based on your active input and stated needs. You will be responsible for working on your identified goals and objectives and CSS staff will be responsible for providing the interventions. This plan can be created with the input of individuals you identify that are important in your recovery, such as family or friends.

Wellness Recovery Action Plan (WRAP): CSS will assist you in creating a WRAP plan, if you desire, which is a tool that can be used to aid in your recovery in the community. Staff will support you in an effort to achieve the wellness and recovery goals outlined in a fully developed WRAP.

Psychiatric Monitoring: The CSS staff will assist you with scheduling and maintaining appointments as well as provide medication education.

Consumer Psycho-education and Support: CSS staff will encourage you to participate actively in your recovery and learn to identify and cope with symptoms as well as adopt the skills you need to manage daily stresses.

Family/Significant Other Education and Support: Within the limits of confidentiality, the CSS staff will initiate ongoing discussion with your family and friends, as well as, staff in other program elements. The staff will meet your family members/significant others in order to help them understand your past experiences, strengths and capacities as well as better understand the course of the illness and strategies that can best help you.

Consumer Advocacy: You will be provided support from staff to learn the skills necessary to advocate on your own behalf. Staff can provide direct skills teaching as well as link you to trainings and activities of the consumer movement.

Employment, Volunteer and Educational Opportunities: Each individual interested in employment will be referred to an employment, volunteer and educational program.

Life Skills Development: CSS will assist you with developing the skills needed to gain access to basic necessities of daily living such as food, clothing, physical health and dental care and safety. This will assure that basic needs are met to enhance recovery and well-being.

Finances, budgeting and banking: CSS will provide training and support in all areas concerned with your finances, including weekly/monthly budgeting, establishing bank accounts, balancing checkbooks, looking for sales, using coupons and rebate offers, avoiding impulse buys, responding to telemarketing or mail "schemes," establishing a savings plan designed for emergencies and enhancing self-sufficiency.

Co-Occurring Disorders: If relevant, CSS will assist you with co-occurring disorders in securing and maintaining involvement in treatment and 12 Step programs. Staff will provide education on the health and social benefits of sobriety. Staff will educate you on the interactive effects of substance use, psychiatric symptoms, and psychiatric medications, and to recognize and manage any substance abusing behavior.

Symptoms Assessment, Management and Supportive Counseling: Symptom assessment is ongoing. Supportive counseling will be provided on an ongoing basis in order to help you adapt and cope with internal and external stresses, self-identify symptoms and develop management techniques. This will assist with relapse prevention and promotion of mental health and well being.

Social, Recreational/Leisure: CSS staff will provide opportunities for regular involvement with the agency, during regularly scheduled social and recreational events. You will have the opportunity to actively participate in the planning and implementation of these events.

Physical Health Care Linkage: CSS will ensure that you have access to medical and dental care, including routine care prevention and wellness services.

Transportation Services: CSS will provide linkage to low cost transportation services. If transportation services are unavailable, direct transportation in an agency vehicle for appointments, shopping, education courses, etc. can be provided.

Benefits/Entitlements: CSS will assess and support your efforts in obtaining public entitlements and benefits including but not limited to Social Security, New Jersey Medicaid, Medicare, welfare, food stamps and Section 8. CSS will assist with the applications and paperwork required as well as assist you with scheduling appointments, accompanying you as needed. I understand that these services will be provided by a multi-disciplinary team of staff who will assist me in achieving and maintaining independent living. A comprehensive rehabilitative needs assessment and individualized rehabilitation plan will be developed based on my active input and stated needs, goals and objectives as well as an outline of how I plan to work on achieving my goals.

I agree to provide a safe and clean environment in my residence so that staff may provide services in this setting. This agreement of safe environment includes an understanding that I will not have any weapons or firearms in the house. I will treat staff and visitors with respect, just as I expect to be treated from staff and visitors.

In the event that I have a house-mate, I agree to practice common courtesy and respect in terms of communication, visitors, cleaning and personal privacy. I understand that if there are difficulties with someone who I live with, I can speak with the team and if necessary, arrange for a house meeting to help mediate or resolve the issues.

I understand that community support services are voluntary and I have the right to refuse these services. In the event that I refuse services and I am residing in a DMHAS subsidized residences I shall admit the CSS staff into the residence, on a monthly basis, to discuss my progress toward my wellness and recovery goals.

I understand that services can be terminated if I:

- Have achieved my service plan goals and do not need any further services;
- Am out of contact with CSS for a continuous period of 90 days, and CSS staff have attempted to engage me through repeated telephone calls, correspondence and home visits;
- Refuse services;
- Move into another residential program;
- Leave the geographic area served by the CSS and services are no longer accessible. In this case, CSS will provide me with a referral for services;
- Repeatedly violate this written rule governing consumer conduct (i.e. verbal abuse, violent behavior, unsafe living environment).

I understand that consequences of violations of any rules or policies of the CSS program or refusal of services, shall not have any effect on eviction from a residence, even if the rent is supported by public funds or a rental unit is owned by MHAEM, and that eviction can only occur with full process of State landlord-tenant law.

I understand that the Division may enter my residence only to the extent and for the purposes that I agree to permit monitoring in writing as part of a consumer services agreement or of an individualized rehabilitation plan. I understand that there is no length of stay requirements in continuing to receive services. I understand that there is no charge to me for the services; however, I agree to have the Mental Health Association of Essex and Morris, Inc. submit claims to Medicaid, Medicare or NJMHAPP depending on my eligibility for reimbursement for services provided. I understand information from my clinical record is entered in Unified Services Transaction Plus Form (USTF) as required by DMHAS

I understand that CSS services are voluntary and are not a requirement as a condition of occupancy, however agree to meet with staff at least once a month. I understand that the policy and procedures manuals are kept in the CSS office and I may ask to review them at any time.

By signing below, I acknowledge that I have received a signed copy of this document.

☐ I understand that I am eligible to receive Community Support Services through the Mental Health Association of Essex and Morris, Inc. I consent to these services which were explained to me by a staff member.

☐ I understand that I am eligible to receive Community Support Services through the Mental Health Association of Essex and Morris, Inc. I currently refuse the services which were explained to me by a staff member. I understand that staff will continue to monitor, contact and motivate me to accept services. I understand that I may agree to accept services at any time.

I understand that I may receive services from a student intern who is under the supervision of a licensed mental health professional at MHA.

I understand and consent that services and/or contact with me may be:

Face to Face

Telehealth/telecommunication

FaceTime

Text

Phone Call

Email

Other

Consumer Resident Signature: sample sample Date:

Witness

Date:

1C-10

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

Morris County Sheriff's Office

P.O. Box 900 • Morristown, New Jersey 07963-0900 • Phone 973-285-6600 • Fax 973-605-8312

James M. Gannon
Sheriff

Mark S. Spitzer
Undersheriff

Richard A. Rose
Undersheriff

Aaron D. Tomasini
Chief



Alan J. Robinson
Undersheriff

Anthony P. Lotz
Warden

John A. Ambrose
Chief Warrant Officer

September 25, 2026

U.S. Department of Housing and Urban Development, Office of Community Planning and Development

RE: Evidence of Coordination and Non-Interference with Local Efforts to Advance Protecting Public Safety, FY 2026 Continuum of Care Program Competition

To Whom It May Concern:

I am writing on behalf of Morris County Sheriff's Office in my capacity as Sheriff to confirm our working relationship with the Morris County Continuum of Care in support of the FY 2026 CoC Program application.

The Morris County Sheriff's Office is responsible for law enforcement and public safety in the CoC's geographic area. Our agency has worked with the CoC through participation in CoC meetings, joint street outreach, and referral coordination.

Based on our experience, I can confirm the following:

1. The Morris County CoC cooperates with the Morris County Sheriff's Office and has not interfered with or impeded our efforts to advance public safety in our community. The CoC also supports first responders in connecting people experiencing homelessness to services.
2. The CoC has not obstructed our efforts to address tents and encampments on public property.
3. The CoC has not obstructed our efforts to reduce public drug use.

U.S. Department of Housing and Urban Development

September 25, 2026

Page 2

4. The CoC has not obstructed our agency from connecting individuals to evaluation, crisis response, or treatment under applicable state and local standards.
5. The CoC has not impeded on information sharing consistent with the Sex Offender Registry and Notification Act (SORNA) and applicable law.

I am available to answer questions about this letter and can be reached at 973.285.6622 or jgannon@co.morris.nj.us.

Sincerely,

A handwritten signature in black ink, appearing to read 'James M. Gannon', with a long horizontal stroke extending to the right.

James M. Gannon
Morris County Sheriff

JMG:nac

1D-1

Local Competition Scoring Tool

Agency Name: _____

Project Name: _____

Project Type: _____

DV Focused Project? _____

Questions for All New Projects - Overall Scope	Possible Score	Score
1. Applicant has a history of successfully administering local or federal funds and completing reporting requirements.	10	
2. Applicant provides (1) depth and breadth of experience providing similar housing services to the homeless; and (2) Depth and breadth of experience providing similar supportive services to the homeless.	10	
3. Applicant Provides a complete and concise description that addresses the entire scope of the proposed project. In order to receive full points, the narrative must address the entire scope of the project, including a (1) clear picture of the community/target population(s) to be served, (2) the plan for addressing the identified needs/issues of the CoC community/target population(s), and (3) projected outcome(s).	20	
4. Applicant demonstrates a plan for rapid implementation of the program; the project narrative must document how the project will be ready to begin housing the first program participant within 6 months of the award.	5	
5. Applicant has a plan for integrating the program into the overall CoC system (CE, HMIS).	5	
6. The project budget will be supplemented with resources from other public or private sources which may include mainstream health, social and employment programs such as Medicaid, Medicare, SSI, and SNAP.	5	
7. Applicant demonstrates the project is necessary to assist people in exiting homelessness and increasing self-sufficiency.	10	
8. Applicant demonstrates that supportive services are a requirement of the program.	10	
9. Applicant demonstrates ability to assist with family or support-network reunification efforts for individuals experiencing homelessness or living in CoC-funded units (e.g., case management, travel costs, arrange of assistance in another geographic area)	5	
Section Total	80	

New Transitional Housing		
1. 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.	10	
2. The applicant has prior experience operating transitional housing or other projects that have successfully helped homeless individuals and families exit homelessness within 24 months or has a plan in place to ensure homeless individuals and families will exit homelessness within 24 months.	5	
3. The applicant has previously operated or currently operates a transitional housing or another homelessness project, or has a plan in place to ensure that at least 50% of participants exit within 24 months and at least 50% exit with employment income.	5	
4. The project demonstrates that the it will provide 20 hours per week of customized services for each participant. The 20 hours a week may be reduced proportionately for participants who are employed and does not apply to participants over age 62 or who have a physical or development disability.	10	
5. The project will assess the service needs of program participants, and create service plans for each participant that include: the services provided, the frequency and timing of those services, the entity responsible for providing the services, the participants goals, the strategies for achieving those goals, and target dates for achievement to focus on improved health, housing stability, and increased employment income.	10	
6. The average cost per household served for the project is reasonable.	5	
7. The project will have substance use treatment available on-site (full points) or off site (half points).	5	
8. The project will require program participant engagement in substance use treatment services as a condition of continued participation in the program	5	
9. Bonus: The project operates sober housing	5	
Section Total	55	

New SSO - Street Outreach Projects		
1. The proposed project has a 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.	10	
2. Demonstrate that the applicant has a history of, or a plan for, 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. The applicant must cooperate and not interfere or impede with the enforcement of 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.	5	
3. The applicant has experience providing outreach services, or a plan for providing outreach services, and has a plan for or has 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.	5	
4. The average cost per household served for the project is reasonable.	5	
Section Total	25	

New SSO - Standalone Projects		
1. The Supportive Services project is necessary to assist people in exiting homelessness, addressing barriers to stable housing (e.g., substance use disorder, unemployment, childcare, etc.) and increasing self-sufficiency and the Recipient will conduct an annual assessment of the service needs of the program participants.	5	
2. The proposed project has a 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.	10	
3. Demonstrate the average cost per household served for the project is reasonable.	5	
Section Total	20	

All New DV Projects		
1. Applicant clearly demonstrates how the project will improve the safety of victims of domestic violence entering the project.	5	
Section Total	5	

Project Budget - All New Projects		
1. Budget items correlate with program design, goals and performance	5	
2. The project will be supplemented with resources from other public or private sources which may include mainstream health, social and employment programs such as Medicare, Medicaid, SSI, and SNAP.	5	
Section Total	10	

Agency	
Project Name	
Project Type	
Operating Year	
Total Contracted # Units	
Total Contracted # Beds	

Evidence	Category	Point Breakdown	Max points per Category	Points Earned
	(1) Target Population			5
Application	% clients who belong to one or more vulnerable subpopulations (chronically homelessness, substance use disorders, mental health conditions, age 55+, developmentally disabled, physically disabled)	5 points		
	Services and Assistance offered are individualized and help clients obtain and retain permanent housing housing			15
Application	(2) Services and Assistance offered are individualized and help clients obtain and retain permanent housing housing	5 points		
	(3) Project will require service participation	10 points		
	Substance Use Treatment			15
	(4) On-site Treatment Capacity			
Application	Active, operational substance use treatment is available on-site	10 points		
	Agency has a formal, signed MOU for substance-use treatment available off-site	3 points		
	No substance use treatment options	0 points		
	(5) The project will require program participant engagement in substance use treatment services as a condition of continued participation in the program	2 points		
	(Bonus) The project operates sober housing	BONUS		
	(6) Cost Effectiveness			10
Project performance data	Meet/Exceed Obligation: The number of positive outcomes (retention of or exit to PH) meet or exceed 100% of the contracted unit/household capacity	10 points		
	Acceptable Range: The number of positive outcomes fall within 85% to 99% of their contracted capacity.	7 points		
	Underutilization: The number of positive outcomes are between 70% and 84% of contracted capacity.	5 points		
	Severe Underutilization: Positive outcomes are below 70% of contracted capacity.	0 points		
	Project Performance			125
	(6) Utilization Rate	10 points		
Project performance data	(7) Employment, Income, and Mainstream Benefits	50 points		
	(8) Housing Stabilization and Returns to Homelessness	40 points		
	(9) PH Projects Only: Length of time to placement in PH			
	≤ 90 days	10 points		
	91-120 days	5 points		
	>120 days	0 points		
Application	(11) Data Quality	10 points		
	(Bonus) At least 25% of clients exited to non-CoC PH	BONUS		
	(10) Expenditure History			10
APR data	Average of 0-10% unspent funds in last 3 completed grant years	10 points		
	Average of 10.1-15% in last 3 completed grant years	5 points		
	Average of > 15% in last 3 completed grant years	0 points		
	(11) Compliance and Findings			20
CoC Monitoring	Zero open HUD Audit Findings	10 points		
	Zero findings from annual CoC monitoring and evaluation	10 points		
	(12) DV Evaluation			5
Application	Applicant clearly demonstrates how the project will improve the safety of victims of domestic violence entering the project.	5 points		

Categories	Max Points	Points Earned
Target Population	5	
Services and Assistance offered are individualized and help clients obtain and retain permanent housing housing	15	
Substance Use Treatment	15	
Cost Effectiveness / Utilization	10	
Project Performance	125	
Expenditure History	10	
Findings and Complaints	20	
DV Evaluation	5	
*Bonus for exits to non-CoC PH (2 points)	N/A	
*Bonus if project operates sober living (2 points)	N/A	
Total Points	205	
Total Score (%)	0	

1D-2c

Local Competition Selection Results

Morris CoC FY2026 Budget

Tier	Rank	Score	Agency Name	Project Name	Program Type	Total Requested	Total Recommended
1	1	95.33%	EDGE New Jersey	EDGE NJ PSH 1 FY2026	PSH	\$ 162,472.00	\$ 150,000.00
1	2	91.78%	EDGE New Jersey	EDGE NJ PSH 2 FY2026	PSH	\$ 122,340.00	\$ 99,000.00
1	3	91.02%	Mental Health Association	PSH for Safe Haven FY2026	PSH	\$ 274,449.00	\$ 230,000.00
1	4	90.25%	Department of Community Affairs	FY2026 3AKNP CoC Renewal	PSH	\$ 335,770.00	\$ 288,000.00
1	6	76.19%	CSPNJ	CSPNJ Coordinated Entry	SSO-CE	\$ 489,587.00	\$ 470,000.00
1/2	7	88.70%	Family Promise of Morris County	Keys 2 Housing Consolidated	PSH	\$ 104,298.00	\$ 100,833.00 3,465.00
DV Bonus		86.75%	JBWS	JBWS Domestic Violence Transitional Grant	TH	\$ 224,371.78	\$ 224,371.00
2	8	96.44%	Family Promise of Morris County	FPMC Transitional Housing	TH	\$ 244,912.00	\$ 244,912.00
2	9	93.45%	EDGE New Jersey	Transitional Housing	TH	\$ 327,298.00	\$ 327,298.00
2	10	90.69%	The Milestone House	Milestone House Recovery and Housing Stability	TH	\$ 302,296.00	\$ 302,296.00
DV Bonus		86.42%	JBWS	JBWS Domestic Violence Transitional Living Prog	TH	\$ 214,500.00	\$ 300,199.00
2	11	91.30%	Family Promise of Morris County	Our Promise Street Outreach	SSO-SO	\$ 220,000.00	\$ 220,000.00
2	12	88.12%	CSPNJ	CSPNJ Street Outreach	SSO-SO	\$ 301,994.00	\$ 66,082.00
N/A			Morris County	Planning Grant	PLANNING		\$ 131,143.00
Total:						\$ 3,039,475.78	\$ 3,157,599.00

			Reallocation	Project		Total	Reallocated amount
		95.68%	Family Promise of Morris County	CE-LSP	SSO-CE	\$ 186,638.00	\$ 186,638.00
	1	95.33%	EDGE New Jersey	EDGE NJ PSH 1 FY2026	PSH	\$0	\$12,472
	2	91.78%	EDGE New Jersey	EDGE NJ PSH 2 FY2026			\$23,340
	3	91.02%	Mental Health Association	PSH for Safe Haven FY2026			\$46,948
	4	90.25%	Department of Community Affairs	FY2026 3AKNP CoC Renewal			\$47,770
	6	76.19%	CSPNJ	CSPNJ Coordinated Entry		\$0	\$19,587
			EDGE New Jersey	RRH for Youth			\$327,298
			JBWS	JBWS Domestic Violence Transitional Grant			\$224,371
						Total:	\$888,424.00
			Rejection	Project		Request	Award

2A-8b

FY 2026 HDX Competition Report

2026 HDX Competition Report

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

To Print this Workbook:

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

To Save This Workbook as a PDF:

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

On Accessibility, Navigability, and Printability:

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

For Questions:

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

2025 HDX Competition Report

2026 Competition Report - Summary

NJ-509 - Morris 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

NJ-509 - Morris 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

NJ-509 - Morris 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	809	160.9	70.0
1.2 Persons in ES-EE, ES-NbN, SH, and TH	904	174.3	91.5

2025 HDX Competition Report

2026 Competition Report - SPM Data

NJ-509 - Morris 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”)	860	455.6	257.5
1.2 Persons in ES-EE, ES-NbN, SH, TH, and PH (prior to “housing move in”)	955	445.4	280.0

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2026 Competition Report - SPM Data

NJ-509 - Morris 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	20	1	5.0%	0	0.0%	0	0.0%	1	5.0%
Exit was from ES	163	28	17.2%	15	9.2%	1	0.6%	44	27.0%
Exit was from TH	54	1	1.9%	1	1.9%	1	1.9%	3	5.6%
Exit was from SH	0	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Exit was from PH	80	2	2.5%	3	3.8%	4	5.0%	9	11.3%
TOTAL Returns to Homelessness	317	32	10.1%	19	6.0%	6	1.9%	57	18.0%

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NJ-509 - Morris 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	913
Emergency Shelter Total	818
Safe Haven Total	0
Transitional Housing Total	128

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NJ-509 - Morris 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)	52
Number of adults with increased earned income	2
Percentage of adults who increased earned income	3.9%

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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)	52
Number of adults with increased non-employment cash income	31
Percentage of adults who increased non-employment cash income	59.6%

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

Metric	Value
Universe: Number of adults (system stayers)	52
Number of adults with increased total income	28
Percentage of adults who increased total income	53.9%

Metric 4.4 – Change in earned income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	11
Number of adults who exited with increased earned income	4
Percentage of adults who increased earned income	36.4%

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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)	11
Number of adults who exited with increased non-employment cash income	2
Percentage of adults who increased non-employment cash income	18.2%

Metric 4.6 – Change in total income for adult system leavers

Metric	Value
Universe: Number of adults who exited (system leavers)	11
Number of adults who exited with increased total income	6
Percentage of adults who increased total income	54.6%

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NJ-509 - Morris 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.	670
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.	215
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)	455

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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.	739
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.	223
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.)	516

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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	156
Of persons above, those who exited to temporary & some institutional destinations	17
Of the persons above, those who exited to permanent housing destinations	15
% Successful exits	20.5%

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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	669
Of the persons above, those who exited to permanent housing destinations	145
% Successful exits	21.7%

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	177
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	174
% Successful exits/retention	98.3%

2025 HDX Competition Report

2026 Competition Report - SPM Data

NJ-509 - Morris 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)	822	128	183	103	271
Total Leavers (HMIS)	559	59	27	49	150
Destination of Don't Know, Refused, or Missing (HMIS)	97	0	0	0	0
Destination Error Rate (Calculated)	17.4%	0.0%	0.0%	0.0%	0.0%

2025 HDX Competition Report

2026 Competition Report - SPM Notes

NJ-509 - Morris 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

NJ-509 - Morris 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	392	345	362	0	362	95.3%
SH	0	0	0	0	0	NA
TH	125	91	91	0	91	100.0%
RRH	68	29	34	0	34	85.3%
PSH	231	199	231	0	231	86.1%
OPH	84	0	84	84	0	NA
Total	900	664	802	84	718	92.5%

2025 HDX Competition Report

2026 Competition Report

NJ-509 - Morris County CoC

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	392	30	30	0	30	100.00%
SH	0	0	0	0	0	NA
TH	125	34	34	0	34	100.00%
RRH	68	34	34	0	34	100.00%
PSH	231	0	0	0	0	NA
OPH	84	0	0	0	0	NA
Total	900	98	98	0	98	100.00%

2025 HDX Competition Report

2026 Competition Report

NJ-509 - Morris County CoC

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	392	375	392	95.66%
SH	0	0	0	NA
TH	125	125	125	100.00%
RRH	68	63	68	92.65%
PSH	231	199	231	86.15%
OPH	84	0	0	NA
Total	900	762	816	93.38%

2025 HDX Competition Report

2026 Competition Report - HIC Summary

NJ-509 - Morris 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

NJ-509 - Morris County CoC

For PIT conducted in January/February of 2026

Submission Information

Date of PIT Count	Received HUD Waiver
1/27/26	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	477	473	398
Safe Haven Total	0	0	0
Transitional Housing Total	112	83	99
Total Sheltered Count	589	556	497
Total Unsheltered Count	91	62	30
Total Sheltered and Unsheltered Count*	680	618	527

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	57	56	46
Total Unsheltered Count	33	29	13
Total	90	85	59

3A-DP

Your CoC's Policy or Statement to Advance Recovery

Family Promise of Morris County
CSPNJ

Milestone House

MHA

JBWS

**Morris Continuum of Care
Certification to Advance Recovery**

The Morris County Continuum of Care is committed to helping people experiencing homelessness achieve stability, health and recovery. We recognize that substance use disorders are factors that may contribute to homelessness and so recovery should be encouraged through all CoC funded projects. For this reason, the CoC is asking all CoC funded providers to certify the following:

- CoC-funded housing projects will not operate drug injection sites or “safe consumption sites”, knowingly distribute drug paraphernalia on or off property under its control, knowingly permit the use or distribution of illicit drugs on property under its control, or conduct any of these activities under the pretext of “harm reduction”; and
- All CoC-funded projects should encourage and provide opportunity for households to receive substance use disorder treatment and recovery housing, when needed.

By signing this certification, the agency is acknowledging that:

- The Morris County Continuum of Care will not restrict or prohibit CoC-funded housing projects that require program participants to be sober or to participate in treatment as a condition of assistance; and
- If an organization has signed this form, but does not adhere to the certifications listed above, it will be evaluated by the CoC Executive Committee for continuation of its Continuum of Care funding.

Agency Certification:

Agency Name: Family Promise of Morris County

Names of CoC Funded Projects: Keys to Housing Consolidated, CE-Landlord Support, Our Promise Street Outreach, & FPMC Transitional Housing

Name : Joann Bjornson

Signature:



**Morris Continuum of Care
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Agency Certification:

Agency Name: Collaborative Support Programs of New Jersey, Inc.

Names of CoC Funded Projects: Morris County Coordinated Entry & Morris County Street Outreach

Victor Luna
Name


Signature

Chief Executive Officer
Title

September 24, 2026
Date

**Morris Continuum of Care
Certification to Advance Recovery**

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Agency Certification:

Agency Name: The Milestone House

Names of CoC Funded Projects: Milestone House Recovery and Housing Stability Initiative

Nikoleta Danicic

Name

Nikoleta Danicic

Signature

Executive Director

Title

9/24/2026

Date

**Morris Continuum of Care
Certification to Advance Recovery**

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- If an organization has signed this form, but does not adhere to the certifications listed above, it will be evaluated by the CoC Executive Committee for continuation of its Continuum of Care funding.

Agency Certification:

Agency Name: Mental Health Association of Essex & Morris INC.

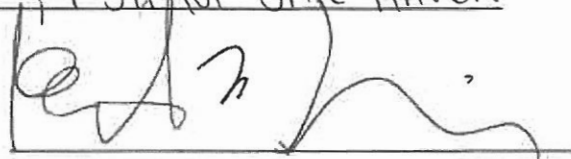
Names of CoC Funded Projects: 3AX, 3AKNP, PSH for SAFE HAVEN

Robert N. Davison

Name

CEO

Title



Signature

**Morris Continuum of Care
Certification to Advance Recovery**

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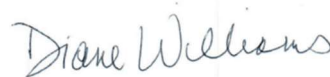
Agency Certification:

Agency Name: Jersey Battered Women's Service, Inc.

Names of CoC Funded Projects: JBWS Domestic Violence Transitional Living Program
& JBWS Domestic Violence Transitional Grant

Diane Williams

Name



Signature

President & CEO

Title

9/22/2026

Date