NEW TRANSITIONAL HOUSING PROJECTS

CT Balance of State Primer with Sample Language

This packet is designed to help providers applying for FY2026 CoC-funded Transitional Housing (TH) projects – whether as a new bonus project or as a transition grant converting an existing Permanent Housing to TH – prepare strong, complete applications in e-snaps.

Questions and Support

CoC Team: ctboscoc@gmail.com | Subject line: “New Application Question(s)"

Organization of Packet

This document is organized in two parts:

- Part 1 - Pre-Application Primer: Explains what a TH project is, what HUD's specific requirements are for new TH projects under the FY2026 NOFO (including the 20-hour weekly service engagement requirement and the 8-point quality threshold), how to approach your budget, and the additional requirements that apply to transition grant applicants.
- Part 2 – Application Section Templates: Narrative sample language and guidance for screens 2B, 3B, and 4A – the three narrative sections most critical to scoring. Each section includes a brief starting framework to customize, green guidance boxes explaining what reviewers are looking for, and for 2 sections – a pre-submission checklist to verify your response is complete before pasting into e-snaps.

How to Use This Packet

1. Part 1 will save you time and help you understand what you are building in e-snaps and what reviewers will be scoring.
2. Gather your information. Before drafting narratives, pull together: your organization's federal grant history and outcome data; your list of partner organizations; your staffing plan and proposed budget; and your housing model and target population description.
3. Use the templates in Part 2 as a starting point, not a finished product. Customize every sentence to reflect your specific project. Fields marked [LIKE THIS] in yellow are fill-ins — but read every sentence and make sure it accurately describes your program.
4. Complete the checklist at the end sections 3B and 4A before pasting your narrative into e-snaps.
5. Verify that all responses are consistent across screens (4A services table, 4B housing type, 5A/5B participants, 6F budget).

- *Note: This packet complements, but does not replace, the annotated New Project Application template and HUD's detailed instructions on HUD Exchange.*

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Questions and Support

CoC team: ctboscoc@gmail.com | Subject line: *'New Application Question(s)'*
FY 2026 NOFO: https://www.hud.gov/sites/dfiles/CPD/documents/CoC/FY2026-CoC-Program-NOFO.pdf
E-snaps Guides and Instructions: https://www.hudexchange.info/e-snaps/

Part 1: Pre-Application Primer

This section explains what you are building, what HUD requires, and how to approach your budget.

What Is Transitional Housing (TH)?

TH provides up to 24 months of temporary housing with intensive supportive services to help people move from homelessness to stable, permanent housing as quickly as possible. Unlike PSH, TH is time-limited and structured around active engagement — participants are expected to work toward self-sufficiency, housing stability, and employment throughout their stay. TH counts as homelessness in HUD performance data, so the goal is to move people through the program efficiently, ideally within 12 months.

Eligible housing models: single-site/congregate (dorms, private/semi-private rooms); scatter-site apartments master-leased by the agency; scatter-site with individual leases and subleases to participants ('transition in place'); SRO units for youth.

Well-suited target populations: people**,** including youth and young adults, in life-stage transitions, people in substance use recovery, domestic violence survivors, people recovering from a serious medical condition, families (focus on income and stabilization).

FY 2026 NOFO Requirements for New TH Projects

Quality Threshold: New TH projects must score at least 6 of 8 available points or be rejected. Projects funded under transition grants are also subject to this threshold.

Pts	Quality Threshold Criterion
2	Demonstrate project will provide and/or partner to provide supportive services to assist participants to obtain and maintain housing (case management, behavioral healthcare, employment training, etc.)
2	Describe how project will: (1) assess service needs AND (2) provide individualized services resulting in at least 20 hours/week of engagement in services, activities, or employment. Describe individualized service plans with goals, strategies, and target dates.
1	Applicant has prior TH experience helping people exit homelessness within 24 months, OR has a written plan to ensure this outcome.
1	Plan ensures at least 50% exit to a positive destination AND at least 50% exit with employment income (within 24 months).
1	Project supplemented with other public/private resources (Medicaid, SSI, SNAP, mainstream services, etc.).
1	Average cost per household is reasonable (2 CFR 200.404).

General Application Threshold Requirements

In addition to the quality threshold above, ALL new project applications must meet the following general threshold requirements or be rejected [§V.A.4.a]:

- Project applicant and any potential subrecipients meet CoC Program eligibility requirements described in the Act and the Rule, and provide required evidence of eligibility (e.g., nonprofit documentation).
- Project applicant and subrecipients demonstrate financial and management capacity and experience to carry out the project and administer federal funds.
- The population to be served meets program eligibility requirements as described in the Act, the Rule, and §III.G.11 of the NOFO.
- Project applicant agrees to participate in a local HMIS system (victim service providers must use a comparable database).
- Project applicant submits all required certifications specified in the NOFO.
- Project applicant certifies affirmatively that it will not engage in illegal racial discrimination, consistent with 2 CFR 200.300(a).

- Project applicant certifies affirmatively that it will not operate drug injection / "safe consumption" sites, knowingly permit the use or distribution of illicit drugs on its property, or distribute drug paraphernalia (21 U.S.C. 856(a)(1)–(2), 863).
- Past performance and eligibility support that the applicant can adequately manage federal awards and comply with all applicable federal laws (HUD reserves the right to verify).

20-Hour Service Engagement — Details:

- Employment counts toward the 20 hours/week. Examples of other qualifying activities: case management, counseling, treatment, volunteering, work therapy, education, job training, community-building. Sample 20-hr service schedule
- Exceptions — the 20-hour requirement does NOT apply to: participants over age 62; individuals with a handicap (24 CFR 8.3); individuals with a developmental disability (24 CFR 578.3). Note: these definitions are narrower than PSH disability definitions.
- Service participation requirements must be codified in a written agreement (sample agreement) with each participant.

HUD Policy Priorities — your application must describe how your project addresses:

- Economic self-sufficiency and employment income — plan to increase earned income
- Access to substance use and mental health treatment as pathways to self-sufficiency
- Exits to unsubsidized permanent housing (not just any PH exit)
- Minimizing length of time homeless — TH counts as homelessness in HUD's data
- Trauma-informed, participant-centered services and public safety
- No distribution of drug paraphernalia on property — applicants must certify this

Tip: Use this document to assist with language adjustments in alignment with HUD priorities

HUD Performance Benchmarks:

≥50% exit to permanent housing | ≥50% exit with employment income | ≥20% exit to unsubsidized housing | <8% return to homelessness within 2 years

CT BOS Performance Benchmarks (use these when they exceed the HUD benchmarks above):

Exit to permanent housing: Regular TH – 90% | Youth TH – 85% | YHDP/Youth Crisis TH – 60%

When describing your agency's prior outcomes, only state those that meet or exceed the HUD standard. When describing projected outcomes, use whichever benchmark is higher — HUD's or CT BOS's.

How to Think About Your Budget

Important: Nonprofits may not administer Rental Assistance (RA) in TH projects.

- Option 1 — Leasing + Operating (most nonprofits): Your agency master-leases units. Use leasing and/or operating budget lines for housing costs. Operating covers maintenance, security, utilities, furniture.
- Option 2 — RA with eligible administrator: If using tenant-based RA, the applicant must be DOH, or you must partner with a PHA. Cannot be used for transition grants (cannot change applicant in transition grant - creates a funding gap).

Supportive Services Budget:

- Budget enough to actually deliver 20 hours/week of service engagement. HUD will assess whether the budget supports the described model.
- Every line item requires a quantity AND description — staff titles, FTEs, salaries, fringe rates, and expense details. Generic descriptions will not pass review.
- Recommended Case Manager caseload: 1:10 to 1:15. Suggested minimum CM salary: $50,000.

- If a service is in the SS budget, it must also be indicated on the 4A Supportive Services screen. 'Partner' on 4A requires a signed MOU or other formal agreement.

HMIS:

- CT BOS requires the inclusion of $1 to the HMIS budget for all new projects – including transitioning projects, to potentially enable usage of unspent funds in that category.

Match:

- Minimum 25% of total assistance requested, excluding leasing. Do not overcommit — HUD monitors against the full committed amount. Attach commitment letters.

Admin:

- Summary Budget, line 10: may not exceed 10% of total CoC program cost subtotal. Entered directly on the Summary Budget screen. Admin costs are direct costs and may not overlap with any indirect costs applied to the project.

Transition Grant Applicants: Additional Requirements

- Only the recipient of the renewal grant being reallocated may apply. Amount requested cannot exceed the Annual Renewal Amount (ARA) of the reallocated grant(s).
- Operating start date = day after the current grant ends. No funding gap. For projects reallocated from more than one grant, start date is the day after the earliest expiring term.
- Must be fully operational as TH by end of the 1-year grant term. 18-month grant terms are not allowed for transition grants.
- Screen 3A, Q.7: Select Yes. In Q.7b, describe how you will wind down the PH component, protect current PH participants from homelessness, and confirm full TH operations within 12 months.
- Screen 7A: Attach the most recent (FY2024 for most) project application for the expiring grant.
- You may reconfigure the budget: add/remove line items, move funds, change household counts or populations. PH participants being reduced must have a documented housing plan.
- Budget must reflect the project's costs when it is fully transitioned to TH. Once awarded, applicants will work with the Field Office as the project moves from PSH to TH.

Questions: ctboscoc@gmail.com | Subject line: 'New Application Question(s)' | See 2026 NOFO FAQs & Provider Updates for current guidance.
This document is a pre-application orientation — not a substitute for the annotated New Project Application template or HUD's detailed instructions.

Part 2: Application Section Templates

How to use this template:

- This template provides a starting framework. Customize every sentence to reflect your specific project — your population, your housing model, your services, your partners, and your outcomes.
- Fields marked [LIKE THIS] require your specific information. Yellow highlighting marks every fill-in field, but don't stop there – read every sentence and make sure it accurately describes your project.
- GREEN sections (like this box) are guidance notes.
- Complete BOTH the recipient section and the subrecipient section if applicable. If DMHAS or DOH is the recipient, use specific text provided to you related to DMHAS/DOH for the recipient portion. Then add your subrecipient response below it. If you are the applicant (not DMHAS/DOH, customize the language to reflect that.
- Character limits apply in e-snaps (character limits given below). Draft in Word, using the word count feature, then paste verifying text fits.
- Be as specific and concrete as possible — use dollar amounts, numbers of grants/clients, percentages, and years of experience rather than general statements.
- When describing outcomes achieved, remove any that do not hit the following HUD benchmarks: ≥50% exits to permanent housing | ≥50% exit with employment income | ≥20% exit to unsubsidized housing | <8% returns to homelessness within 2 years.
- When describing proposed outcomes, ensure that the match or exceed those listed above.

2B. Experience of Applicant, Subrecipient(s), and Other Partners

Question 1: Effectively utilizing federal funds and performing proposed activities (3,000 character limit without spaces)

What this question is looking for (per NOFO threshold criteria):

- Prior experience operating transitional housing OR other programs that have helped people exit homelessness within 24 months
- If no TH experience: experience with similar projects (case management, housing stabilization, RRH, PSH) that demonstrates you can help people exit homelessness and reach permanent housing within 24 months — especially unsubsidized PH
- For both of above – experience serving same/similar population and helping to identify and provide housing & supportive service needs, develop and implement similar programs and services
- Use concrete data: $$ amounts of federal grants managed, # clients served, % exits to PH, % with employment income, audit results
- Include both recipient (DMHAS or DOH) and subrecipient responses as appropriate.

Tip: Address TH experience (or comparable experience) explicitly — this maps directly to 1 of the 8 quality threshold points.

RECIPIENT (DMHAS or DOH — use the specific DMHAS/DOH text provided, then add subrecipient below):

[Insert recipient experience text here — if DOH/DMHAS is recipient]

SUBRECIPIENT — Use and customize the block below:

Version A: If you have prior TH experience

Through a competitive process, **[Organization Name]** has been identified as the project [recipient/subrecipient]. **[Organization Name]** has **[X]** years of experience operating transitional housing and other programs serving people experiencing homelessness using trauma-informed principles. **[Organization**

Name] currently **[operates / has previously operated]** **[X]** transitional housing beds serving **[describe population, e.g., adults experiencing chronic homelessness / youth / DV survivors]**. During this time participants increased self-sufficiency by participating in activities similar to the ones planned in this project. This is demonstrated by the following outcomes: **[X%]** of program participants exited the program within 24 months, and **[X% (only enter if at least 50%)]** exited to permanent housing destinations. Of those permanent housing exits, **[X% (only enter if at least 20%)]** exited to unsubsidized housing.

[Organization Name has (describe any/all similar populations served and years of experience doing so, programs developed and implemented including specific services provided, partnerships developed and positive outcomes achieved]

[Organization Name] has successfully utilized federal funds to best serve people experiencing homelessness. **[Organization Name]** currently manages **[X]** HUD CoC grant(s) totaling **[$X]**, and has administered federal funds totaling **[$X]** over the past **[X]** years, including **[list grant types, e.g., CoC, SAMHSA, ESG, HOME]**. **[Organization Name]**'s use of federal funds has been characterized by timely program startups, achievement of desired outcomes, and submission of accurate and timely reports. **[Organization Name]** has **[never had / successfully resolved]** any HUD monitoring findings and has no unresolved OIG audit findings.

[Organization Name] maintains robust program, quality assurance (QA), and finance systems to ensure effective and compliant use of federal funds. **[Describe briefly: e.g., 'QA staff conduct quarterly file reviews and program data audits. A dedicated finance team manages grant drawdowns, invoicing, and subcontractor oversight in accordance with 2 CFR Part 200.']** **[Organization Name]** program leaders are active participants in CT BOS CoC meetings and trainings and are familiar with CoC Program requirements and HUD performance expectations.

Version B: If you do NOT have prior TH experience (use comparable program experience)

Note: If you don't have prior TH experience, describe the experience you do have. HUD awards 1 point for prior TH experience OR for a written plan demonstrating you can help people exit homelessness within 24 months. Use your strongest comparable programs — RRH, bridge housing, shelter with services, etc.
Lead with exits to permanent housing data. Exits to unsubsidized housing are especially valued under this NOFO.

Through a competitive process, **[Organization Name]** has been identified as the project subrecipient. **[Organization Name]** has **[X]** years of experience operating **[describe comparable programs, e.g., Rapid Rehousing, Shelter, intensive housing-focused case management programs]** serving people experiencing homelessness **[add specific subpopulation information if relevant]** — programs that share the same core activities as the proposed TH project, including housing search, intensive case management, the use of trauma-informed principles, linkages to mental health and SUD treatment, employment support, and housing stabilization **[add other similar activities as relevant].**

Across **[Organization Name]**'s existing programs, **[X% (only enter if at least 50%)]** of program participants have exited to permanent housing destinations, and **[X%]** have exited within **[X]** months. **[X% (only enter if at least 20%)]** of permanent housing exits have been to unsubsidized housing. **[Insert any other strong outcome data: e.g., employment income increases, connections to treatment, returns to homelessness rates, length of time homeless reductions.[1]]**

[Organization Name] has a clear plan to ensure that TH participants exit homelessness within 24 months. **[Summarize your plan in 2-3 sentences: e.g., 'From the first week of program entry, case managers will develop a housing exit plan with each participant. Plans will be reviewed monthly and updated based on**

[1] Add outcomes only if they meet or exceed HUD's Performance Benchmarks listed on p.3.

participant progress. The program will target an average length of stay of [X] months and will connect participants to [specific resources including employment, and substance use disorder treatment and mental health treatment] to support income stability at exit.']

[Organization Name] has successfully utilized federal funds to best serve people experiencing homelessness and total federal funds of **[$X]** over the past **[X]** years, including **[list grant types: other HUD funds, SAMHSA, ESG, HOME]**. **[Organization Name]**'s use of federal funds has been characterized by timely program startups, achievement of desired outcomes, and submission of accurate and timely reports. **[Organization Name]** has **[never had / successfully resolved]** any HUD monitoring findings and has no unresolved audit findings.

[Organization Name] maintains robust program, quality assurance (QA), and finance systems to ensure effective and compliant use of federal funds. **[Describe briefly: e.g., 'QA staff conduct quarterly file reviews and program data audits. A dedicated finance team manages grant drawdowns, invoicing, and subcontractor oversight in accordance with 2 CFR Part 200.']** **[Organization Name]** program leaders are active participants in CT BOS CoC meetings and trainings and are familiar with CoC Program requirements and HUD performance expectations.

Question 2: Experience leveraging Federal, State, local, and private sector funds (3,000 character limit without spaces)

Include:

- Dollar amounts of Fed, state, local, and private sector funds leveraged in recent years. Be specific about sources.
- Both recipient and subrecipient. Describe how funds are braided or coordinated to maximize impact.

RECIPIENT — use provided DMHAS/DOH text as relevant, then add subrecipient below. If no subrecipient, simply use text below.

SUBRECIPIENT:

As the project's [**recipient/subrecipient**], **[Organization Name]** has extensive experience leveraging federal, state, local, and private funds to ensure programs are adequately resourced to produce successful outcomes. **[Organization Name]** currently has an annual operating budget of **[$X]**, comprised of **[list funding sources and approximate amounts or percentages, e.g., 'federal HUD and SAMHSA grants ($X), State of CT Department of Housing ($X), CT Department of Mental Health and Addiction Services ($X), City of [X] ($X), and private foundation grants ($X)']**. **[These funds are often braided / These funding streams are coordinated]** to maximize both direct service capacity and administrative resources.

[Add any specific leveraging examples with dollar amounts, e.g., 'In [Year], [Organization] leveraged $X in HHS funds alongside $X in CoC funds to provide co-located mental health services to [X] participants.'].

Question 3: Financial management structure (3,000 character limit without spaces)

Describe how your organization has a functioning accounting system operated in accordance with generally accepted accounting principles (GAAP), or that you have designated a fiscal agent.
If you have a subrecipient, describe their fiscal controls and accounting procedures (required under 2 CFR Part 200).
If DMHAS / DOH is the recipient – start with description of their state agency financial management systems. Subrecipients should describe their agency-specific systems.
Include: accounting software used, internal and external controls, audit history, and how you ensure compliance with 2 CFR Part 200.

RECIPIENT — use provided text for DOH/DMHAS if they are recipient as appropriate. Then add subrecipient response. If only recipient – adjust text below for recipient.

SUBRECIPIENT:

[Organization Name] maintains a robust financial management system that ensures accurate and compliant use of federal funds in accordance with 2 CFR Part 200. **[Organization Name]** uses **[name of accounting software, e.g., Sage Intacct, MIP Fund Accounting]** to manage all grant accounts. Financial oversight is provided by **[describe structure, e.g., 'a Chief Financial Officer who reports to the Executive Director and Board of Directors. The agency has a Finance Committee of the Board that reviews financial statements quarterly.']** Internal controls include **[describe, e.g., 'segregation of duties, dual-signature requirements for disbursements over $X, monthly account reconciliation, and regular internal audits.']**

[Organization Name] undergoes an annual independent audit in accordance with the Single Audit Act. **[Organization Name]** has **[had no material weaknesses or significant management recommendations / successfully addressed all prior audit findings]** in its annual audits. **[Organization Name]** has no unresolved monitoring or OIG audit findings for any federally-funded program.

Program expenses are charged to the appropriate grant in accordance with **[Organization Name]**'s cost allocation plan. Indirect costs **[are not charged to this grant / are charged at the de minimis rate of 15% per 2 CFR 200.414(f) / are charged at the organization's federally negotiated indirect cost rate of X%]**. **[Organization Name]** has never had a grant placed in corrective action with any federal funder.

3A. Transition Grant Applicants Only: Question 7b — Transition Description

Draft this section for transition grants alongside your 3B narrative since the content is closely related. Required content per the NOFO:

- How you will reduce activities in the old component as you transition (and how current participants will not become homeless)
- Estimated date the project will be fully operational as TH — must be within the 1-year grant term
- Amount of funds that will be used to wind down the outgoing component and estimated completion date

Tip: Be specific about current PH participants — how many, and what is the plan for each.

This application requests a transition grant to convert **[Grant Name / Grant Number]**, an existing **[PSH / RRH / Joint TH-RRH]** project, to Transitional Housing. The expiring grant currently serves **[X individuals / households]** with a period of performance ending **[date]**. The new TH project will begin on **[date — day after current grant ends]**. During the transition year, **[Organization Name]** will wind down the **[PSH / RRH]** component while ramping up TH operations. **[Describe the specific wind-down plan for current participants — how many will exit to permanent housing, and by when. Confirm that no current participants will be displaced to homelessness. See suggested draft below.]**The expiring **[PSH / RRH / Joint TH-RRH]** project currently serves **[X]** individuals/households. During the transition year, [**Organization Name]** will strategically reduce enrollment in the outgoing **[PSH / RRH / Joint TH-RRH]** component. Specifically: **[X]** current participants are expected to exit to permanent housing by **[date]** through active housing search support, exit planning, and connection to community resources. No current participants will be displaced to homelessness as a result of this transition — each participant will have an individualized housing plan developed prior to the transition date. Staff will maintain trauma-informed, participant-centered support throughout the transition period, including enhanced case management contact and continuity of care planning for all current participants. **[X]** new TH participants are expected to enter the program by [**date – suggest add date part-way through the year**] through Coordinated Access Network referrals. Approximately **[$X]** of transition grant funds

will be used to wind down outgoing **[PSH / RRH / Joint TH-RRH]** activities, with wind-down expected to be complete by **[date]**. The new TH project is projected to be fully operational by **[date — within 12 months of grant start]**.

3B. Project Description

Tip: 3B maps to threshold points outlined on p.2. Quality threshold criteria should be addressed explicitly — don't assume reviewers will infer it from context. Use the checklist at the end to confirm all necessary components are included before submitting.

Question 1: Describe the entire scope of the proposed project (3,000 character limit without spaces)

Your narrative must address all of the following — customize the template paragraphs below based on your project:

- Target population and their specific housing and service needs
- Housing model (scatter-site or single-site; leasing, operating, or rental assistance)
- How participants will be referred (through the CAN) and how housing will be secured
- Individualized service plans with goals, strategies, and target dates focused on housing stability, employment income, and self-sufficiency
- How participants will be engaged in at least 20 hours/week in services, activities, or employment (sample service schedule)
- Direct services provided by the recipient/subrecipient and other community services that will be provided by partners/external agencies — name partners with specific roles
- Connections to employment services/assistance gaining employment income, substance use treatment and mental and physical healthcare and social supports
- Exit planning toward permanent, unsubsidized housing within 24 months or less
- Specific outcome targets aligned with HUD benchmarks
- Why CoC funding is needed
- Service participation requirement — describe your written service agreement with participants (service agreement template)

Note: Make sure your description is consistent with screens 4A (services), 4B (housing type), 5A/5B (participants), and 6F (budget). Reviewers flag inconsistencies.

[Organization Name] will provide Transitional Housing (TH) services to **[X individuals / X households]** experiencing homelessness who meet HUD's Category 1, 2 or 4 homeless definition. **[Describe your target population and their specific housing and service needs — e.g., adults in substance use recovery, youth ages 18–24, DV survivors.]** All participants will be referred through the CT Balance of State Coordinated Access Network (CAN). The project will operate as **[a scatter-site program / a single-site congregate program]**, providing up to 24 months of housing assistance through **[tenant-based rental assistance / agency master-leased units / operating funds]**.

Upon program entry, each participant will receive a comprehensive assessment of their housing and service needs. Within **[X days]** of entry, the Case Manager and participant will jointly develop an individualized service plan including the services to be provided, how often and by whom, participant goals and strategies for achieving them, and target dates for achievement — with a focus on housing stability, health and wellness, employment income, and self-sufficiency. Plans will be reviewed and updated **[monthly / at minimum every 90 days]**. The program will ensure that each participant is engaged in at least 20 hours per week in services, activities, or employment. **[Describe how 20 hours/week will be structured — e.g., case management appointments, group programming, treatment, employment or job training activities, community-based**

activities.] This requirement does not apply to participants over age 62 or to individuals with a qualifying handicap or developmental disability.

Services will be provided directly by **[Organization Name]** staff and through partnerships with community organizations using trauma-informed principles. Direct services include **[list direct services — e.g., housing-focused case management, housing search and placement, life skills training, peer support, substance use treatment, mental health treatment/care]**. Through agreements with partner organizations, participants will also have access to **[list partner services and partner names — e.g., substance use treatment through [Partner], mental health services through [Partner], physical healthcare through [Partner], employment and job training through [Partner]]**. Staff will assist with referrals, transportation, and follow-up to ensure participants are connected and engaged with services, building resource connections that will help sustain participants through program exit and lead to self-sufficiency.

All program activities are oriented toward helping participants exit to permanent housing within 9 - 12 months. From program entry, case managers will work with each participant on a housing exit plan that prioritizes unsubsidized permanent housing and builds the income and skills needed to sustain housing independently. **[Describe your exit planning approach and any specific strategies for your population.]** The average projected length of stay is less than 12 months. The anticipated project outcomes are: **[adult TH - 90%; Youth TH - 85%; YHDP Crisis TH – 60%]** of participants will exit to permanent housing; ≥20% of permanent housing exits will be to unsubsidized housing; ≥50% will exit with employment income; and fewer than 8% will return to homelessness within two years.

CoC Program funding is essential to this project because **[explain why — e.g., no other funding source provides housing assistance combined with intensive services at this intensity for this population]**. CoC funding will not duplicate other resources available to participants. In accordance with CT BOS CoC policy, participants will be required to participate in supportive services as a condition of program participation. **[Briefly describe your service participation agreement — e.g., 'Each participant will sign a written service agreement at program entry outlining service participation expectations, individualized goals, and the process for addressing non-participation.']**

Pre-Submission Checklist: Does Your 3B Narrative Address These?

- ☐ Target population described — who is being served and why they need TH
- ☐ Housing model described (scatter-site or single-site; leasing, operating, or RA)
- ☐ Referrals through the CAN stated
- ☐ Individualized service plans described — goals, strategies, target dates, focused on housing stability, employment income, self-sufficiency
- ☐ 20 hours/week service engagement described — how structured
- ☐ Exceptions to 20-hour requirement noted (age 62+, qualifying handicap/developmental disability)
- ☐ Direct services listed
- ☐ Partner organizations named with specific roles
- ☐ SUD and mental health treatment access described
- ☐ Employment and employment income-building support described
- ☐ Exit planning described — targeting permanent, unsubsidized housing
- ☐ Average/projected length of stay stated

☐ Outcome targets stated (≥50% PH exits, ≥50% with employment income, ≥20% unsubsidized PH, <8% returns to homelessness)

☐ Why CoC funding is needed — brief statement included

☐ Service participation requirement described

☐ Trauma-informed care referenced

☐ Narrative is consistent with screens 4A, 4B, 5A/5B, and 6F

☐ Transition grants: wind-down plan on Screen 3A (Q7b) with timeline and participant protection

4A. Supportive Services for Participants

How to use this section:

- Questions 1a, 1b, 1c, and 2 together map to 4 of the 8 quality threshold points for new TH projects — specifically the 2 points for services/obtaining-maintaining housing (Q1b/1c) and 2 points for assessing service needs and providing 20-hrs/week engagement (Q2). Thin or generic responses risk losing those points.
- As with other sections of this resource, the language below is sample language. This section, in particular, has some brief responses. You are encouraged to elaborate on experience and/or plans that your agency has related to the particular questions
- The 4A Services Table (Q3, not covered here) must be consistent with this narrative and with your 6F Supportive Services budget. Every service listed in the SS budget must appear on the 4A table as recipient, subrecipient, or partner. "Partner" requires a signed MOU.

Question 1a [1 threshold point]

What prior experience does the applicant have 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?

Character limit: 3,000 (no spaces)

What this question is looking for:

- Prior experience with TH or other programs (RRH, shelter, intensive CM) that have helped people exit homelessness within 24 months — including housing search, landlord engagement, lease-up support, barrier removal, financial literacy, and job placement.
- If no prior TH experience: a written plan demonstrating how the project will ensure exits within 24 months.
- Include concrete data where available: % exits to PH, % exits with employment income, % exits to unsubsidized housing, average length of stay.
- Only include outcomes that meet or exceed the applicable CT BOS benchmark (Regular TH: 90% exit to PH / 40% increased earned income; Youth TH: 85%/25%; YHDP Crisis TH: 60%). If your data falls below the benchmark, describe your plan to reach it instead.

Tip: This question maps directly to 1 threshold point. Address it explicitly even if your comparable experience is not TH.

Version A — If you have prior TH experience:

[Organization Name] has **[X]** years of experience operating transitional housing programs serving **[describe population, e.g., adults, families, youth, DV survivors]**. **[Organization Name]** currently **[operates / has previously operated]** **[X]** transitional housing beds. During this time, **[X%]** of program participants exited within 24 months, and **[X%]** exited to permanent housing destinations. Of those exits, **[X%]** were to unsubsidized housing, and **[X%]** had employment income at exit.

[Organization Name] supported participants to exit homelessness within 24 months through trauma-informed housing-focused case management, active housing search support, landlord engagement, and income-building strategies beginning at program entry. Staff assisted participants with **[describe barrier removal approach, e.g., rental history remediation, credit repair, employment connections, healthcare connections, treatment services/connections, community and family connections/unification, life skills training, budgeting]**. **[Organization Name/Organization's program name has partnerships/MOUs with (describe any**

partnerships/MOUs or relationships with local healthcare providers, treatment centers, employment resources, food pantries, job training / placement centers, other education providers, childcare centers) which have facilitated the success of our participants in exiting to permanent housing and being able to maintain that housing by [describe how partnerships have helped . . . e.g. helping participant stabilize in housing, learn tenancy skills that they could bring forward into permanent housing, helped to treat healthcare, mental health, substance use issues so that participants could move forward to permanent housing with a sustainable plan.] Case managers created individualized services plans, including exit plans, within **[X]** days of enrollment and updated **[monthly / at minimum every 90 days]**, with a focus on creating meaningful goals for each participant, including identifying a target permanent housing placement and building the income and skills needed to sustain it.

Version B — If you do NOT have prior TH experience (use comparable program experience):

Note: HUD awards 1 point for prior TH experience OR a credible written plan. Strong comparable programs: RRH, housing focused case management, intensive shelter services, bridge housing.

Lead with your strongest exit data — especially exits to unsubsidized PH and exits with employment income. Only cite outcomes that meet the applicable benchmark.

[Organization Name] has **[X]** years of experience operating **[describe comparable programs, e.g., Rapid Rehousing, Supportive Housing Program, housing focused case management, shelter with intensive services]** serving people experiencing homelessness — programs that require the same core competencies as the proposed TH project, including housing search, intensive case management, barrier removal, income support, and housing stabilization.

Across **[Organization Name]**'s existing programs, **[X%]** of participants have exited to permanent housing, and **[X%]** have exited within **[X]** months. **[X%]** of exits were to unsubsidized housing. **[Insert any other strong outcome data: employment income increases, returns to homelessness rates.]**

[Organization Name] has a clear plan to ensure that TH participants exit homelessness within 24 months. **[Describe your plan, e.g., 'From day one of program entry, case managers will develop a housing exit plan with each participant. Plans will identify the participant's target housing type, income pathway, and projected exit timeline. The program will target an average length of stay of [X] months. Staff will connect participants to [specific income/employment resources] and [housing resources] to build the financial foundation for independent housing.']**

Question 1b

Describe how this project will improve participant and CoC outcomes by increasing housing stability and ensuring participants exit to permanent housing. (See also: 3B Project Description for outcome targets.)

Character limit: 3,000 (no spaces)

What this question is looking for:

- A plan ensuring at least 50% exit to a positive destination AND at least 50% exit with employment income — both within 24 months. This maps to 1 threshold point.
- The plan for reducing length of time homeless (TH counts as homelessness in HUD data — length of stay should be as short as possible).
- Exits to unsubsidized housing are especially valued under this NOFO.

Tip: State your outcome targets explicitly. Only cite outcomes that meet the CT BOS benchmark (see 1a guidance). State how you plan to achieve them.

[Organization Name] is committed to ensuring that the large majority of program participants exit to permanent housing, prioritizing unsubsidized housing options, within the shortest time possible. **[Organization Name]** will target that **[at least [X]%]** of participants exit to permanent housing destinations within their program period, and that **[at least [X]%]** exit with employment income.

To achieve these outcomes, case managers develop individualized service plans, including exit plans, with each participant within **[X]** days of enrollment based on their needs assessment and goals. These plans identify the participant's target permanent housing type, projected exit date, income sources at exit, and remaining barriers to independent housing. Plans are reviewed and updated **[monthly / at minimum every 90 days]** to reflect participant progress. Staff prioritize connections to unsubsidized housing — including market-rate rentals, shared housing, and family reunification — and work with participants to build rental history, credit, and savings during the program. Using trauma-informed methods, case managers work with participants to make connections to services needed to gain stability, employment income and skills to exit to and sustain permanent housing.

Based on our previous work with the population proposed in this program **[list population and relevant experience], [Organization Name]** knows that the participants will need targeted case management and connections to services such as: **[list as relevant - substance use treatment, assistance with community connections, job training, life skills training, mental health treatment, medical care, housing search assistance, tenancy skills - list all relevant services.] [Organization Name will work with – list local organizations that will assist with the above-listed services – to gain the services and skills needed to increase housing stability, and exits to permanent housing.]**

To minimize length of stay, **[Organization Name]** implements a housing-focused case management model in which housing planning begins at enrollment — not at the point of exit. Staff actively track participant progress toward income and housing goals and adjust support accordingly. The program will target an average length of stay of 9-12 months, with the understanding that some participants may exit sooner and a small number may need more than 12 months.

Question 1c [2 points]

Demonstrate that 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 (i.e., case management, behavioral healthcare, employment training, etc.)

Character limit: 3,000 (no spaces)

What this question is looking for (2 points):

- The full range of supportive services the project will provide or arrange — case management, behavioral healthcare, employment training, and other services necessary for participants to obtain and maintain housing.
- Who provides each service: recipient, subrecipient, or partner (partner = signed MOU required).
- How services connect to housing stability and employment outcomes.
- Trauma-informed care as a program-wide practice, not an add-on.

Tip: This is the primary vehicle for the 2 "supportive services" threshold points. Be specific about what services are offered, by whom, and how they connect to housing stability.

The text below is more than 3,000 characters. Customize to fit your program and trim as necessary.

[Organization Name] will provide a comprehensive array of supportive services designed to help participants obtain housing, maintain it, and ultimately move on to self-sufficiency. Trauma-informed care and Motivational Interviewing principles guide all aspects of case management — staff recognize the impact of trauma on participants' ability to engage with services and housing, and use strengths-based approaches throughout the program.

Core Case Management Services (provided by [Recipient / Subrecipient]):

- Case managers will carry a caseload of **[X]** participants providing intensive, housing-focused care. Services will include: comprehensive intake and needs assessment; individualized service plan development and regular updates; housing search, unit identification, and landlord engagement; lease-up support; tenant rights and lease education; and ongoing tenancy support.
- Case managers will actively monitor housing stability intervening early as issues arise — including landlord-tenant disputes, lease violations, and rent arrears. Staff will provide or arrange financial literacy and budgeting coaching, with a focus on rent payment, utility management, and saving toward housing costs at exit.
- Exit planning begins at enrollment, is updated **[monthly]** and identifies target housing type, income pathway, and projected exit date. Upon program exit, participants are connected to community-based supports to ensure housing retention.

Behavioral Healthcare and Treatment Services (provided by / connected to [Recipient / Subrecipient / Partner [name]]):

- **[Organization Name]** connects all participants to mental health and substance use treatment as needed. **[Describe your approach, e.g., "Staff conduct a mental health and SUD screening at intake using [tool]. Participants identified with MH or SUD needs are referred to [Partner Organization] for [specific services: outpatient mental health, MAT, SUD treatment, peer recovery support]."]** Staff provide referrals, support transportation, and follow up within **[X]** days to confirm connection.
- **[[If applicable: A Peer Recovery Specialist employed by / contracted through [Organization] works directly with participants with substance use or mental health challenges, providing peer support, connection to treatment, and crisis linkage.]]**

Employment and Income Support Services (provided by / connected to [Recipient / Subrecipient / Partner [name]]):

- A primary goal of the program is to increase participants' employment income. **[Describe employment support, e.g., "Case managers assess employment readiness at intake and connect employment-ready participants to [American Job Centers / WIOA programs / local workforce board / vocational training programs] for vocational assessment, job readiness training, resume development, and job placement support. For participants with barriers to traditional employment, staff explore transitional work, volunteer opportunities, and work therapy that also count toward the 20-hour weekly engagement requirement."]**

- **[[If serving families: Staff assist participants with childcare barriers to employment through applications to subsidized childcare programs including Care4Kids.]]**

Additional Supportive Services:

- **[Organization Name]** provides or connects participants to the following additional services as needed: **[list relevant services and providers, e.g., legal services (partner: [X]); healthcare through FQHC/CHC connection ([X]); life skills and tenancy training; transportation assistance; food assistance; childcare; and educational services.]**

Formal Partnership Network:

[Organization Name] maintains formal partnerships with the following organizations that provide services to program participants: **[list partners with specific roles, e.g., '[Partner A] — outpatient SUD treatment and MAT; [Partner B] — employment readiness and job placement; [Partner C] — legal services; [Partner D] — mental health services; [Partner E] — healthcare/FQHC']**. All partners listed on the 4A services table have a current, signed MOU with **[Organization Name]**. Staff make active referrals, provide transportation assistance as needed, and follow up with participants and partners to confirm engagement.

Question 2 [1 point points]
Describe the specific plan to coordinate and integrate with mainstream health, social services, and employment programs for which program participants may be eligible.
Character limit: 3,000 (no spaces)

What this question is looking for (1 point):

- How participants will be assisted to obtain and INCREASE EMPLOYMENT income — lead with this.
- Social services access (SNAP, TANF, childcare, food assistance, legal, transportation).
- Healthcare and benefits: Medicaid, Medicare, FQHC connections, healthcare for the homeless.
- SUD and mental health treatment — a specific NOFO priority; describe treatment access, MAT, and peer support.
- SSI/SSDI/SOAR technical assistance for participants who are not employment-ready.

IMPORTANT: Under this NOFO, employment income is strongly prioritized over benefits income. Lead with employment — describe workforce connections before listing benefits programs. Benefits are framed as transitional support while participants build toward employment and self-sufficiency.

Note: Drug paraphernalia certification belongs in this section — include it explicitly.

A primary goal of this project is to increase participants' employment income, building the financial stability needed to sustain permanent housing after program exit. Staff assess employment readiness at intake and develop an employment plan as part of each participant's individualized service plan. **[Organization Name]** connects employment-ready participants to **[describe workforce resources, e.g., American Job Centers, WIOA-funded workforce programs, local employer partnerships, vocational training programs, community college programs]** for vocational assessment, job readiness training, resume development, and job placement support. Staff assist with transportation to employment appointments and training. For participants with

barriers to traditional employment, staff explore transitional work, volunteer opportunities, and work therapy programs that build work history and skills while also contributing to the 20-hour weekly engagement requirement. **[[If serving families: Staff assist participants with childcare needs that are a barrier to employment through applications to subsidized childcare programs including Care4Kids and other local providers.]]**

Access to healthcare and behavioral health treatment is a core component of this project. **[Organization Name]** connects all participants to health insurance coverage upon enrollment and assists participants in establishing care with a primary care provider through **[name local FQHC or healthcare for the homeless program, e.g., Community Health Center, Inc. / Charter Oak Health Center / [local CHC]]**. For participants with substance use disorders, staff **[describe SUD treatment connections, e.g., "provide warm referrals to outpatient SUD treatment through [Partner]; connect participants to medication-assisted treatment (MAT) providers; and facilitate referrals to peer recovery support specialists and recovery community organizations."]** For participants with mental health needs, staff **[describe MH service connections, e.g., "connect participants to outpatient mental health services through [Partner] and facilitate referrals to psychiatric services as needed."]**

[Organization Name] maintains formal partnerships with the following organizations that provide mainstream services to program participants: **[list partners with specific roles, e.g., '[Partner A] — outpatient SUD/MAT treatment; [Partner B] — employment services; [Partner C] — legal services; [Partner D] — mental health services; [Partner E] — healthcare/FQHC']**. Staff make active referrals and provide transportation assistance as needed, and follow up within **[X days]** of each referral to confirm participant connection and engagement with services. Annual benefits renewals are tracked and supported.

Question 3a / 3b [2 points]

3a: How will this project assess the service needs of program participants?

Character limit: 3,000 each (no spaces)

3b: Describe how this project will provide individualized services for program participants during their time in Transitional Housing that will result in at least 20 hours per week of engagement in services, activities, or employment for all program participants, except for a program participant over age 62 or who is an individual with handicaps as defined in 24 CFR 8.3 or with a developmental disability as defined under 24 CFR 578.3. (Examples: case management, counseling, treatment, volunteering, work therapy, education, job training, community-building activities. Employment may contribute to the 20 hours per week. The project description provided here does not constitute a reporting or documentation requirement.)

Character limit: 3,000 each (no spaces)

What this question is looking for (2 points — the highest-value pair):

- 3a: How you assess service needs — what tool/method, when, how often updated, who conducts it.
- 3b: How individualized services will result in at least 20 hours/week of engagement. Be concrete — describe how the 20 hours are structured and what activities count.
- Service plans for each participant including: (1) services to be provided, when, how often, by whom; (2) participant goals, strategies, and target dates — focused on health/wellness, housing stability, and increased employment income leading to self-sufficiency.

- Exceptions to the 20-hour requirement: age 62+; individuals with a handicap per 24 CFR 8.3; individuals with a developmental disability per 24 CFR 578.3.
- *Tip: These two questions together earn 2 of the 8 threshold points. Write them as a pair but address each question distinctly.*

3a — Needs Assessment:

[Organization Name] uses a standardized, trauma-informed intake and needs assessment process to understand each participant's housing history, strengths, barriers, service needs, and goals at program entry. The assessment is conducted by the assigned case manager within **[X]** days of enrollment using **[describe your assessment tool or approach, e.g., "a comprehensive intake tool that covers housing history, mental health, substance use, employment, income, benefits, legal issues, family needs, and accessibility requirements"]**. Assessment results are used immediately to develop the participant's individualized service plan and to identify referrals to community-based services. Service needs are reassessed **[monthly / at minimum every 90 days]**, and any time there is a significant change in the participant's situation.

3b — 20-Hour Weekly Engagement:

[Organization Name] structures each participant's program participation to ensure at least 20 hours per week of engagement in services, activities, or employment — except for participants age 62 or older, those with an eligible handicap, or those with an eligible developmental disability. Employment counts toward the 20-hour requirement, and the project is designed so that participants who are employed full-time meet the requirement through their employment alone. Upon project entry, participants sign a service agreement whereby they agree to take part in services needed to stay housed, and the program commits to providing the necessary services and supports.

For participants who are not yet employed full-time, the 20 hours per week of engagement are structured around a combination of the following activities tailored to each participant's service plan: **[list activities, e.g., "weekly case management meetings (1–2 hrs); individual counseling or therapy sessions (1 hr); group programming including life skills, financial literacy, and tenancy classes (2–4 hrs/week); job training, education, or vocational programming (variable); substance use treatment or recovery support group attendance (variable); volunteering or work therapy activities (variable); medical or behavioral health appointments and treatment groups (variable); employment search and interview preparation activities (variable)"]**. **[A Sample Weekly 20-Hour Service Schedule for this program is available — this is a provider resource to help conceive of a services schedule. Links cannot be made to the e-snaps application.]**

Within **[X, e.g., 30]** days of program entry, the case manager and participant jointly develop an individualized service plan. Each plan includes:

- **Services to be provided:** specific services, how often each will occur, and who will provide them (recipient, subrecipient, or named community partner)
- **Participant goals:** specific goals in the areas of health and wellness, housing stability, and increased employment income/financial self-sufficiency, with strategies for achieving each goal, specific tasks indicating who is responsible for each, and target dates for achievement
- **20-hour schedule:** a weekly schedule identifying how the participant will meet the 20-hour engagement requirement, with flexibility built in to adjust as circumstances change

[If relevant – list any on-site substance use treatment services that is available to participants and/or may be a requirement of the program]

Service plans are reviewed and updated with the participant **[monthly / at minimum every 90 days]** and whenever there is a significant change in the participant's situation. Trauma-informed care principles guide the service planning process — plans are developed collaboratively, build on participant strengths, and are adjusted based on participant feedback and progress.

Pre-Submission Checklist: Does Your 4A Narrative Address These?

Question 1a (prior experience / plan — 1 threshold point)

☐ Prior TH or comparable program experience described

☐ Outcome data cited meets or exceeds CT BOS benchmark (Regular TH: 90% PH exit / 40% earned income; Youth TH: 85%/25%; YHDP Crisis TH: 60%). Only cite data that clears the bar.

☐ If no TH experience: a credible written plan is provided for ensuring exits within 24 months

☐ Average length of stay target is stated and as short as possible (TH counts as homelessness)

Question 1b (outcomes plan — scored via 1c/2)

☐ Outcome targets stated (at least 50% exit to PH; at least 50% exit with employment income)

☐ Unsubsidized housing exits prioritized and described

☐ Housing exit planning process described — started at enrollment, updated regularly

☐ Length of stay minimization approach described

Question 1c (supportive services — 2 threshold points)

☐ Core case management services described — intake/assessment, housing search, landlord engagement, lease-up, tenancy support

☐ Barrier removal described — what barriers and how addressed

☐ Behavioral health / SUD / MH service connections described with named partners

☐ Employment support described — workforce connections, training, job placement

☐ Full service list provided with providers identified (recipient / subrecipient / partner)

☐ All partners have signed MOUs (required to select "partner" on 4A services table)

☐ Trauma-informed care is a definitive program practice — not "if applicable"

☐ Post-exit support and community connections described

☐ 1c narrative is consistent with 4A services table and 6F SS budget

Question 2 (mainstream coordination — 1 threshold point)

☐ Employment support led — workforce connections described FIRST before benefits

☐ Childcare support described (if serving families or working-age adults with children)

☐ FQHC or healthcare for the homeless connection named

☐ SUD treatment access described explicitly — treatment connections, MAT, peer support

☐ Mental health services access described

☐ Other social services listed (legal, food, transportation)

☐ Partners named with specific roles; active referral and follow-up process described

☐ Q2 is consistent with services listed in 4A services table and 6F SS budget

Questions 3a/3b (service needs assessment + 20-hr engagement — 2 threshold points)

☐ Needs assessment tool/method described — what it covers, when conducted, by whom

☐ Frequency of reassessment stated

☐ 20-hour weekly engagement structure described — what activities count and how they are arranged

☐ Employment explicitly described as counting toward 20-hour requirement

☐ Individualized service plans described with all required elements: services/schedule/provider; goals/strategies/target dates focused on health, housing, employment income, and self-sufficiency

☐ Service plan review frequency stated (monthly recommended)

☐ Trauma-informed, participant-centered approach to service planning described

Questions: ctboscoc@gmail.com | Subject line: "New Application Question(s)"