**FORM 5 – CONTINUUM OF CARE (CoC) VERIFICATION**

**VERIFICATION OF PARTICIPATION**

TheVerification of Participation Form must be completed to include the number of CoC meetings held, the number of meetings attended by a representative of your agency, and a signature from the CoC’s authorized person.

GROUP INFORMATION

Name of CoC Attended: **Enter name**

Type of CoC Meetings Attended:

Regional Coalition

Committee

Subcommittee

Task Force

Workgroup

Name of CoC Authorized Person/Chair: **Enter name**

Authorized Person/Chair Email: **Enter Email**

Authorized Person/Chair Phone Number: **Enter phone number**

AGENCY INFORMATION

Agency Name: **Enter name**

Name(s) of Staff that Attended Meeting(s): **Enter name(s)**

MEETING INFORMATION (to be completed by the CoC Authorized Person)

Number of CoC Meetings Held: **Enter number**

Number of CoC Meetings Attended by Staff from this Agency: **Enter number**

Did the agency consult the CoC for project approval while preparing the 2024-25 NHAP application and its proposed activities?

YES NO

Do the agency’s proposed NHAP activities align with the CoC’s priorities for serving persons experiencing homelessness and persons at risk of homelessness?

YES NO

I verify the above information is accurate and current.

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Signature of CoC’s Authorized Person Date