**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