

## HCCSD Continuum of Care Monthly Project Status Report

Subrecipient Agency: \_\_\_\_\_

Project Name: \_\_\_\_\_ Project No. TX \_\_\_\_\_

Operating Year: (*month/day/year to month/day/year*): \_\_\_\_\_

Reporting Month: \_\_\_\_\_ Number of months into the reporting period: # \_\_\_\_\_ / 12 = \_\_\_\_\_%

Number of units capacity goal: \_\_\_\_\_ Current capacity: \_\_\_\_\_

If not at 100% capacity, explain why and plan to meet capacity:

\_\_\_\_\_  
\_\_\_\_\_

### Checklist of Reports attached:

- Household Characteristics Report (if applicable)
- Rent Calculation Worksheets and Income Source Documentation (if applicable)
- New Leases (if applicable)
- Participant Discharge Summaries
- HMIS Print-Out of APR Report:
  - Q7- Data Quality
  - Q8 - Number of Persons Served
  - Q9 - Households Served
- Reimbursement Request (if applicable)
- Quarterly Persons Served Worksheet
  - 1<sup>st</sup> Quarter
  - 2<sup>nd</sup> Quarter
  - 3<sup>rd</sup> Quarter
  - 4<sup>th</sup> Quarter
- Other: \_\_\_\_\_

*I certify that CoC participant information for this grant is current in the Homeless Management Information System:*

\_\_\_\_\_/\_\_\_\_\_

*Signature/Date*

Project Monitor's comments/Date approved:

\_\_\_\_\_

Manager's comments/Date approved:

\_\_\_\_\_