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 Reports:
  - ☐ Data Quality
  - ☐ Persons Served with Details
- ☐ Reimbursement Request (if applicable)

- ☐ 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:

_____