SHELTER PLUS CARE CASE MANAGER REPORT

CLIENT NAME: ____________________________

CASE MANAGER: ____________________________ CASE MANAGER AGENCY: ____________________________

PERIOD: May 1, 20____ - April 30, 20____

1. What services were provided? What referrals were provided for other services?
   ______________________________________________________________________________________
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2. Was the Annual assessment of service needs conducted? ____________________________

3. What non-cash income did the client receive (if any)?
   a. SNAP (food stamps): YES NO
   b. Medicaid: YES NO
   c. Medicare: YES NO
   d. CHIP: YES NO
   e. WIC: YES NO
   f. VA: YES NO
   g. TANF childcare: YES NO
   h. TANF transportation: YES NO
   i. TANF other __________________
   j. Insurance other _______________

Client ____________________________________________ Date ______________________

OR

Case Manager __________________________________________ Date ______________________