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**EQUAL HOUSING OPPORTUNITY • EQUAL OPPORTUNITY EMPLOYER** 

## **SHELTER PLUS CARE CASE MANAGER REPORT**

CLIENT NAME:				
CASE MANAGER:			CASE MANAGER AGENCY:	
PERIO	D: May	, 1, 20 April 30, 20		
1.	What services were provided? What referrals were provided for other services?			
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		- ( d.,,,,	
		Medicaid: YES NO		
	c.	Medicare: YES NO		
	d.	CHIP: YES NO		
	e.	WIC: YES NO		
		VA: YES NO		
	•	TANF childcare: YES NO		
		TANF transportation: YES NO		
	i.	TANF other		
	j.	Insurance other		
Client			Date	
OR				
Case Manager			Date	