

FFT™ Income Supports Counseling Service Entry

(Required elements are underlined.)

Client Name: _____

Date: _____

Start time: _____

Duration (in minutes): _____

Staff Person: _____

Contact Location/Method: In person By phone By email By fax
 By mail By text message By social media Other

Did you reach the person you attempted to contact? Yes No

Contact with: Client Employer Service Provider Other

General Benefits Screening Results:

- Declined screening
- Did not complete screening
- Client receiving all available benefits at this time
- Completed screening: eligible for at least one benefit
- Completed screening: not eligible for any benefits

Eligible for the following benefits:

- Child Care Subsidies
- FAFSA
- Financial Aid (grants)
- Head Start/Early Head Start
- Medical Benefits/Health Insurance
- Other Non-Recurring Assistance (cash or non-cash)
- Recurring Cash Assistance/Payments
- SNAP (food stamps and comparable programs)
- Subsidized Housing
- Unemployment Compensation
- Utility Assistance
- WIC (Women, Infants & Children)

| Topic | Name of Entity | Status | Frequency of Payment/ Subsidy (see codes below)* | Amount of Benefit/ Subsidy | Details |
|------------------------|----------------|--------|---|-------------------------------|---------|
| Child Care Subsidies | | | | | |
| FAFSA | | | | | |
| Financial Aid (grants) | | | | | |

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| | | | | | |
|--|--|--|--|--|--|
| <p>Head Start/Early Head Start</p> | | | | | |
| <p>Medical Benefit/Health Insurance</p> | | | | | <p>Type of medical benefit/subsidy:</p> <ul style="list-style-type: none"> <input type="checkbox"/> General health insurance <input type="checkbox"/> Single medical exam/service (not <input type="checkbox"/> dental/vision) <input type="checkbox"/> Single dental exam/service <input type="checkbox"/> Single vision exam/service <input type="checkbox"/> Dental insurance <input type="checkbox"/> Vision insurance <input type="checkbox"/> Long-term care insurance <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Medicare Supplemental Health Insurance <input type="checkbox"/> Low Income Subsidy (Medicare Part D) <input type="checkbox"/> Medicare Savings Program <input type="checkbox"/> Patient Assistance Program <input type="checkbox"/> State Prescription Assistance Program <input type="checkbox"/> Other <p>If other, please specify:</p> |

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| | | | | | |
|--|--|--|--|--|---|
| Other Non-Recurring Assistance (cash or non-cash) | | | | | Type of Non-Recurring Assistance <input type="checkbox"/> Cash <input type="checkbox"/> Non-cash If cash, please specify: <input type="checkbox"/> Rent/Mortgage <input type="checkbox"/> Food Assistance <input type="checkbox"/> Utilities (gas/electric, hotspots, wifi and/or internet) <input type="checkbox"/> Childcare <input type="checkbox"/> Laptops/tablets <input type="checkbox"/> Healthcare/Medical bills <input type="checkbox"/> Debt (credit cards, loans, etc.) <input type="checkbox"/> Personal Items If non-cash, please specify: |
| Recurring Cash Assistance/Payments | | | | | Type of Recurring Cash Assistance/Payments: <input type="checkbox"/> TANF <input type="checkbox"/> GA <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Social Security (retirement) <input type="checkbox"/> Other If other, please specify: |
| SNAP (food stamps and comparable programs) | | | | | |
| Subsidized Housing | | | | | |
| Unemployment Compensation | | | | | |
| Utility Assistance | | | | | |
| WIC (Women, Infants & Children) | | | | | |

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**Frequency of Payment/Subsidy codes:*

| | |
|-----------------|--------------------|
| One time | Every two months |
| Every week | Every three months |
| Every two weeks | Every six months |
| Every month | Every year |

Notes: _____

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