

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 video conference 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> <hr/>

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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"/> Home Repair <input type="checkbox"/> Personal Items If non-cash, please specify: <hr style="width: 100%;"/>
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: <hr style="width: 100%;"/>
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 week

Every two weeks

Every month

Every two months

Every three months

Every six months

Every year

Notes: _____

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