

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

Digital Skills Training/Navigation: Yes No

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					

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Financial Aid (grants)					
Head Start/Early Head Start					
Medical Benefit/Health Insurance					Type of medical benefit/subsidy: <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 If other, please specify:

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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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