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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(Required elements are underlined.)

Financial Aid (grants)					
Head Start/Early Head Start					
Medical Benefit/Health Insurance					**Type of medical benefit/subsidy:** ❑ General health insurance ❑ Single medical exam/service (not ❑ dental/vision) ❑ Single dental exam/service ❑ Single vision exam/service ❑ Dental insurance ❑ Vision insurance ❑ Long-term care insurance ❑ Medicare Part D ❑ Medicare Supplemental Health Insurance ❑ Low Income Subsidy (Medicare Part D) ❑ Medicare Savings Program ❑ Patient Assistance Program ❑ State Prescription Assistance Program ❑ Other **If other, please specify:** _____

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(Required elements are underlined.)

Other Non-Recurring Assistance (cash or non-cash)					**Type of Non-Recurring Assistance** ❑ Cash ❑ Non-cash **If cash, please specify:** ❑ Rent/Mortgage ❑ Food Assistance ❑ Utilities (gas/electric, hotspots, wifi and/or internet) ❑ Childcare ❑ Laptops/tablets ❑ Healthcare/Medical bills ❑ Debt (credit cards, loans, etc.) ❑ Personal Items **If non-cash, please specify:** _____
Recurring Cash Assistance/Payments					**Type of Recurring Cash Assistance/Payments:** ❑ TANF ❑ GA ❑ SSI/SSD ❑ Social Security (retirement) ❑ 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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(Required elements are underlined.)

**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:_____