



Supportive Services Checklist

Consumer First, Last _____	Date MM/DD/YY _____	Location: <input type="checkbox"/> This Program Site <input type="checkbox"/> Consumer Residence <input type="checkbox"/> Consumer Workplace <input type="checkbox"/> Other Program Site: _____ <input type="checkbox"/> Other Service Provider _____ <input type="checkbox"/> Hospital <input type="checkbox"/> Jail <input type="checkbox"/> Other Site
Contact Duration Hours, Minutes _____	Time of Contact Hours, Minutes, AM/PM _____	Face to Face Y/N _____

Primary Problem Area (Please Circle ONE):

Case/Care Management
 Clothing
 Consumer Assistance and Protection
 Criminal Justice/ Legal Services
 Day Care
 Day Shelter
 Education
 Employment
 Food
 Food Bag
 Health Care
 HIV/AIDS - Related Services
 Housing Placement
 Laundry
 Locker/Storage
 Mail
 Material Goods
 Meals
 Mental Health Care/Counseling
 Mortgage Assistance
 Other Service Type
 Outreach
 Personal Enrichment
 Phone Call
 Referrals Out
 Rent Assistance
 Security Deposit Assistance
 Shower
 Substance Abuse Services
 Temporary Housing/Other Financial Aid
 Transportation
 Utility Assistance

Service	Units	Service Details	Service	Units	Service Details
<input type="checkbox"/> Case/Care Management	_____	_____	<input type="checkbox"/> Material Goods	_____	_____
<input type="checkbox"/> Clothing	_____	_____	<input type="checkbox"/> Meal	_____	_____
<input type="checkbox"/> Consumer Assistance and Protection	_____	_____	<input type="checkbox"/> Mental Health Care/Counseling	_____	_____
<input type="checkbox"/> Criminal Justice/Legal Services	_____	_____	<input type="checkbox"/> Mortgage Assistance	_____	_____
<input type="checkbox"/> Day Care	_____	_____	<input type="checkbox"/> Other Service Type	_____	_____
<input type="checkbox"/> Day Shelter	_____	_____	<input type="checkbox"/> Outreach	_____	_____
<input type="checkbox"/> Education	_____	_____	<input type="checkbox"/> Personal Enrichment	_____	_____
<input type="checkbox"/> Employment	_____	_____	<input type="checkbox"/> Phone Call	_____	_____
<input type="checkbox"/> Food	_____	_____	<input type="checkbox"/> Referral Out	_____	_____
<input type="checkbox"/> Food Bag	_____	_____	<input type="checkbox"/> Rent Assistance	_____	_____
<input type="checkbox"/> Health Care	_____	_____	<input type="checkbox"/> Security Deposit Assistance	_____	_____
<input type="checkbox"/> HIV/AIDS - Related Services	_____	_____	<input type="checkbox"/> Shower	_____	_____
<input type="checkbox"/> Housing Placement	_____	_____	<input type="checkbox"/> Substance Abuse Services	_____	_____
<input type="checkbox"/> Laundry	_____	_____	<input type="checkbox"/> Temporary Housing/Other Financial Aid	_____	_____
<input type="checkbox"/> Locker/Storage	_____	_____	<input type="checkbox"/> Transportation	_____	_____
<input type="checkbox"/> Mail	_____	_____	<input type="checkbox"/> Utility Assistance	_____	_____

Disabling Condition:

<input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Yes	_____	Yes: (Select One) <input type="checkbox"/> Diagnosable substance use disorder <input type="checkbox"/> Serious mental illness <input type="checkbox"/> Developmental disability <input type="checkbox"/> Chronic physical illness or disability
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