Attachment A

SERVICE AND BI-WEEKLY PLAN/INDEPENDENT LIVING PLAN FOR FAMILIES

TODAY'S DATE:	FACILITY NAME:

CLIENT NAME:	APT #:	INITIAL SERVICE /INDEPENDENT LIVING PLAN ☐	BI-WEEKLY REVIEW ☐	DATE OF ADMISSION:

OTHER ADULT:	FAMILY COMP: ADULTS: CHILDREN:	PA/HRA#	S.S.#	OTHER #

P.A. STATUS: OPEN ☐ CLOSED ☐ PEND ☐ INELIGIBLE ☐ SANCTIONED ☐		HOUS. CERTIFIED ☐ TYPE:

SERVICE NEED	TASK DESCRIPTION (CLIENT/STAFF RESPONSIBILITY)	SERVICE PROVIDER/AGENCY	START DATE	COMPL. DATE

TYPES OF SERVICE NEEDS CHECKLIST

HOUSING EDUCATION BENEFITS PARENTING SKILLS LEGAL SERVICES DOMESTIC VIOLENCE

CHECK DOCUMENTS NEEDED

Birth Cert. ☐ Medicaid Card ☐

CHILD/REC	JOB TRAINING	CHILD WELFARE	UNDOCUMENTED INDIVIDUAL	SUBSTANCE/ALCOHOL ABUSE	MENTAL HEALTH	P.A. Card ☐	SS Card ☐
COUNSELING	EMPLOYMENT	MEDICAL	INDEPENDENT LIVING SKILLS	COMMUNITY TIES	OTHER	Medicals ☐	Immunization ☐
						Passport ☐	Food Stamp ☐
						Budget Sheet ☐	Other _____

DATE OF NEXT BI-WEEKLY REVIEW:	EXPECTED DURATION OF THA:

I have assisted in the development and understand the above Service/Independent Living Plan, as required by regulations, as a provision for achieving self-sufficiency and housing. I further understand that failure to comply with the development and completion of this plan, any Public Assistance or housing requirement as prescribed in 18 NYCRR Sections 352.35 & 900.10 (c) (1), may result in the discontinuance of my temporary housing. Attachment A also contains requirements that you must meet. Please see Attachment A for these additional requirements.

Client's Signature: Date:	Caseworker's Signature: Date:

Other Adult Signature: Date:	Supervisor's Signature: Date:

COMMENTS:

cc: Original to File
Copy to Client

Pages _____ of _____