

Attachment A

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

TODAY'S DATE:	FACILITY NAME:
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CLIENT NAME:	APT #:	INITIAL SERVICE /INDEPENDENT LIVING PLAN <input type="checkbox"/>	BI-WEEKLY REVIEW <input type="checkbox"/>	DATE OF ADMISSION:
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OTHER ADULT:	FAMILY COMP: ADULTS: CHILDREN:	PA/HRA#	S.S.#	OTHER #
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P.A. STATUS: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> PEND <input type="checkbox"/> INELIGIBLE <input type="checkbox"/> SANCTIONED <input type="checkbox"/>	HOUS. CERTIFIED <input type="checkbox"/> TYPE:
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SERVICE NEED	TASK DESCRIPTION (CLIENT/STAFF RESPONSIBILITY)	SERVICE PROVIDER/AGENCY	START DATE	COMPL. DATE

HOUSING EDUCATION BENEFITS [TYPES OF SERVICE NEEDS CHECKLIST](#) 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

COUNSELING EMPLOYMENT MEDICAL INDEPENDENT LIVING SKILLS COMMUNITY TIES OTHER

P.A. Card SS Card

Medicals Immunization

Passport Food Stamp

Budget Sheet Other

DATE OF NEXT BI-WEEKLY REVIEW:	EXPECTED DURATION OF THA:
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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: _____
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Other Adult Signature: _____ Date: _____	Supervisor's Signature: _____ Date: _____
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COMMENTS: _____ _____ _____

cc: Original to File
Copy to Client

Pages _____ of _____
