CASE MANAGEMENT TAB Checklist HMIS#:

|  |  |  |
| --- | --- | --- |
| Participant Name: | Date Completed | Staff Initials |
| Required for ENROLLMENT |  |  |
| Case Notes (can be printed from HMIS)- update monthly |  |  |
| Budget- update monthly*-give copy to participant* |  |  |
| Self Sufficiency Action Plan- update monthly |  |  |
| Rental Calculation (complete monthly for RRH)MOVE IN DATE:  |  |  |
| Staff Certification of Enrollment*-MUST be signed by Homeless Housing management* |  |  |
| Completed forms uploaded into HMIS |  |  |
| Required for EXIT |  |  |
| Program Exit Form (must be HMIS printout) |  |  |
| Program Termination Letter  |  |  |
| Landlord Notification of Participant Termination Letter  |  |  |
| Completed tab uploaded into HMIS |  |  |

*Case notes & accompanying documents should be placed in the file by date, most recent on top.*

CASE NOTES

\*\*ALL RRH SERVICES MUST BE ENTERED INTO HMIS\*\*

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Date & Time** | **Services Provided:****Case Management****Housing Search Assistance****Financial Assistance** | **Notes** |
|  |  |  |
|  |  |  |
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Budget Worksheet

PARTICIPANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Complete at:

 Enrollment Move In

|  |  |  |
| --- | --- | --- |
| Monthly Expenses | Estimated Amt | Actual Amt |
| Rent  |  |  |
| Utilities: Electric PIPP: Will Apply Enrolled: Y N |  |  |
|  Gas PIPP: Will Apply Enrolled: Y N  |  |  |
|  Water |  |  |
|   |  |  |
| Cell phone  |  |  |
| Food expenses covered by SNAP benefit  | ( ) | ( ) |
| Food expenses (ONLY include *if* HH need exceeds SNAP benefit) *\*Calculates @ $50/person weekly (ex: 2 person HH; 50x2=100wkly. 100 x4= 400 monthly)* |  |  |
| Baby Formula and/or Diapers |  |  |
| Transportation: (car payment, gasoline or transportation fare) |  |  |
| Child Care |  |  |
| Medical ( prescriptions, co-pays, medicine needs) |  |  |
| Insurance ( Automobile, Renters) |  |  |
| Household Supplies |  |  |
| Personal Needs (clothing, haircut, shoes, etc) |  |  |
| Tobacco Use |  |  |
| School Expenses (fees, lunches, books, tuition, etc) |  |  |
| Installment loans or other Debt Payments (Payday Loans, Fines, Court Costs, etc.) |  |  |
| Storage Unit (\**NOT counted when housed*) |  |  |
| Child Support Payments |  |  |
| Savings (please specify) |  |  |
| Other (please specify) |  |  |
|  |  |  |
| A: *TOTAL MONTHLY COSTS* Exclude Food expenses covered by SNAP benefit |  |  |
| B: *TOTAL NET MONTLY INCOME*Include: Wages, child support, SSI, OWF (any eligible income): *Do NOT include SNAP benefit.* |  |  |
| C: ADJUSTED MONTHLY INCOME(Total NET Monthly Income – Total Monthly Costs) |  |  |
| Monthly Rent Contribution? 🞏 30% (less than 30% AMI) 🞏 50% (greater than 30% AMI) 🞏 NO\*  |
| \*If no, please use the space below to explain extenuating circumstances (emergency/large expenses) that prevents the household from contributing to their housing burden (30% for those with income below 30% AMI or 50% for those with incomes greater than 30% AMI): |

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ \_\_\_\_\_

Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ \_\_\_\_\_

Self Sufficiency Action Plan

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Action Component | Current Status for Participant | Case Manager Responsibilities | Participant Responsibilities | Date(s) Achieved |
|  Income-type of income |  | Update file as needed |  |  |
| Employment:-name of employer-status PT/FT |  | Update file as needed |  |  |
|  Housing  Situation |  | Provide Housing Resource | Participant is activelyseeking housing |  |
|  Food |  | Provide Community Resource | Utilize Food Pantries &SNAP assistance if available |  |
|  Childcare |  | Refer to JFS Childcare if applicable |  |  |
|  Children’s  Education |  | Refer to Head Start if applicable |  |  |
|  Adult  Education |  | Provide if requested |  |  |
|  Legal |  | Refer to SoutheasternLegal Aid (if applicable) |  |  |
| Health Care |  | Refer to JFS for Medicaid if applicable | Maintain JFS apptsor apply if needed |  |
| Life Skills | Refer to Housing History Assessment | Update as needed |  |  |
|  Mental Health |  | Refer to Local Mental Health Agency if applicable |  |  |
|  Substance  Abuse Support |  | Refer to Local Recovery Service if applicable |  |  |
| Support Network: |  | Determined by participant | Determined by participant |  |
| Transportation: |  | Refer to transportation services if applicable |  |  |

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

STAFF CERTIFICATION OF ELIGIBILITY

Purpose: This form serves as documentation that: (1) the program participant named below meets all eligibility criteria for Region 16 housing assistance; (2) this eligibility determination is based on true and complete information; (3) neither the staff member making this determination nor her/his supervisor are related to the program participant through family, business or other personal ties; and (4) this eligibility determination has not resulted from, nor will result in, any financial benefit to the staff member making this determination, his/her supervisor, or anyone related to them.

Instructions: This form must be completed for each program participant upon the determination of her/his – eligibility for Region 16 homeless housing assistance. This form must be signed and dated by homeless housing staff person and homeless housing supervisor who determine a household’s eligibility. This form must be kept in the program participant’s case file. This form will remain valid, unless a different homeless housing staff person re‐determines the household’s eligibility, in which, case a new form will be required.

|  |
| --- |
| Participant Name:  |
| Program:  |
| HMIS Entry Date: |
| \*List additional members of household: |
|  |
|  |
|  |
|  |

*\*All members in household that will benefit from housing assistance must be listed.*

Required certifications: Each person signing below certifies to the following: (1) To the best of my knowledge, the program participant named above meets all requirements to receive assistance under Region 16 housing assistance. (2) To the best of my knowledge and ability, all the information used in making this eligibility determination is true and complete. (3) I am not related to the program participant through family, business, or other personal ties. (4) To the best of my knowledge, neither I, nor anyone related to me, has received, or will receive any financial benefit for this eligibility determination. (5) I understand that fraud is investigated by the Department of Housing and Urban Development, Office of Inspector General, and may be punished under Federal laws to include, but not limited to, 18 U.S.C. 1001 and 18 U.S.C. 641. (6) I understand that if any of these certifications is found to be false, I will be subject to criminal, civil and administrative penalties, and sanctions.

Case Manager Signature: Date:

Supervisor Signature: Date:

COMMUNITY ACTION COMMISSION
1400 ST RT 22NW
Washington Court House, OH 43160
Phone: 740.333.7282
Fax: 740.335.6802

NOTICE OF PROGRAM TERMINATION

|  |  |
| --- | --- |
| Participant Name: | Program:   |
| Street Address: | County:  |
| City, State and Zip Code: | Delivery Date: |
| If you do not understand, or want to talk to someone about it, you may call: |
| Case Manager: | Phone Number: |
| Staff Signature: | Date: |

Program services are conditional on participant complying with the terms set in the Services & Participation Agreement at enrollment. Participants are required to meet with the program Case Manager at least once a month to continue to receive services and/or financial assistance.

* *Program services for your household have been terminated due to:*

COMMUNITY ACTION COMMISSION
1400 ST RT 22NW
Washington Court House, OH 43160
Phone: 740.333.7282
Fax: 740.335.6802

Landlord: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ CAC Housing Program: \_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Re: Participant termination of housing program services

Dear *Landlord name*,

On *enrollment date*, *participant name* was enrolled in a Community Action Commission (CACFC) housing program and approved for financial assistance. Housing program eligibility was established for the following period: *enter time frame*, as outlined in the participants Services and Participation Agreement.

Program participants are required to recertify their income, submit required documents, and meet with their program Case Manager monthly; failure to complete these requirements results in an exit from the housing program. Participants are also exited from their housing program when they successfully stabilize their housing. HUD guidelines require that landlords be notified within 30 days of a participant exiting a housing program.

*Participant name* has been exited from their CACFC Housing program due to:

 Non-compliance with their CACFC housing program.

 Successful completion of their CACFC housing program.

Community Action Commission will no longer provide *participant name* with further financial assistance from this date forward.

If you have any questions or concerns, please feel free to contact me at *agency phone number*.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Case Manager (signature)