

## Shelter Plus Care Supportive Services Report(SC02)

Service Provider:

Period Reported:

Client Name:

<u>Supportive Services</u>	<u>Hours of Service</u>	<u>Amount of Cash Match for Services</u>
Outreach		\$
Case Management		\$
Life Skills (other than CM)		\$
Alcohol/Drug Abuse Services		\$
Mental Health Services		\$
AIDS-related Services		\$
Other Health Care Services		\$
Education		\$
Housing Placement		\$
Employment Assistance		\$
Childcare		\$
Transportation		\$
Legal Assistance		\$
Other (please specify)		\$
Totals		\$

Please return this form monthly to:

Crystal Bastin  
 Idaho Housing and Finance Association  
 PO Box 7899  
 Boise, ID 83707-1899  
 Phone: (208) 331-4799  
 Via fax: (208) 331-4808  
 Via e-mail: [crystalb@ihfa.org](mailto:crystalb@ihfa.org)

### **Treatment Plan Certification**

\_\_\_\_\_ (your agency) certifies that the above individual has a current signed case/treatment plan and has agreed to participate in appropriate supportive services. \_\_\_\_\_ (your agency) also certifies that the above individual will have ongoing assessments to determine the appropriate services needed to fulfill their treatment plan. Copies of that plan are available for review by IHFA upon request.

\_\_\_\_\_  
 Authorized IDHW Representative or  
 Case Worker

\_\_\_\_\_  
 Date