EMERGENCY SHELTER SERVICES

Provider Name \_\_\_\_\_\_\_\_\_

Service Month \_\_\_\_\_\_\_\_\_

1. # Clients Served This Month\*­­­ \_\_\_\_\_\_

2. Occupancy Nights

|  |  |  |
| --- | --- | --- |
| Total Rooms (DPH Funded)\* | Total # Nights this Month\* | Total Possible Occupancy Nights (DPH Funded)\* |
|  |  |  |

3. Total Occupancy Nights Invoiced This Month (DPH Funded)\*: \_\_\_\_\_\_\_\_\_\_\_

4. Did your program provide flex funds this month\*? Yes No (4a-4j will only appear if the answer is yes)

|  |  |
| --- | --- |
|  | # of Clients |
| 4a. # Clients Provided Flex Funds This Month\* |  |

|  |  |
| --- | --- |
|  | Flex Fund $ Amounts  |
| 4b. $ Amount for **Utilities** This Month  | $ |
| 4c. $ Amount of Flex Funds for **Housing** This Month  | $ |
| 4d. $ Amount for **Vehicle Costs** This Month  | $ |
| 4e. $ Amount for **Relocation Costs** This Month  | $ |
| 4f. $ Amount for **Document** **Costs** This Month  | $ |

|  |  |
| --- | --- |
| 4g. $ Amount for **Medical/Dental** **Costs** This Month |  |
| 4h. $ Amount for **Immediate Safety** **Costs** This Month |  |

|  |  |
| --- | --- |
| 4i. $ Amount for **Educational/Occupational Costs** This Month | $ |
| 4j. $ Amount for **Other Costs** This Month  | $ |

For **Other Costs**, please specify other costs for the month invoiced. (Shows up only when Other Costs are indicated)

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Total $ Amount of Flex Funds Provided This Month: (Automatically generated by EIM).

5. OPTIONAL – Please share a story about how flex funds helped a survivor or family. Do not include personally identifying information.

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6. OPTIONAL: Please briefly summarize any accomplishments and/or challenges your program experienced this month.

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Assessment Complete.