Housing Stabilization

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

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Assessment Complete.