CoC Program Annual Assessment
EXAMPLES: Case Notes and Simple Form

8/23/2022
**NOTE:**
ANNUAL ASSESSMENT – Case Manager met with client at client’s apartment. Client started program on 8/29/2021, and CM asked client what’s changed in past year. Client talked about positive changes (housing, therapy, support) and also how she misses her mom and friend who passed away this year. Per annual assessment requirements, CM and client discussed services she’s using: food pantry; mental health counseling; transportation assistance; help with cleaning supplies; Food Share; Social Security; survivor women’s group. Client said she stopped attending the survivor group as she feels she’s getting what she needs through her therapist. Client said she wants to see an eye doctor and maybe a dentist, but she’s nervous about going to the dentist because it’s been many years. CM will work on referrals for dentist and eye doctor.

Feb 2023

BADGER HOUSING INC

CoC Program Annual Assessment Form

**SAMPLE** (usable form on page 2)

Client Name: **Mary Smith** Today’s Date: **2/16/2023**Case Manager Name: **Jane Addams** Project Start Date: **2/23/2022**
Current Supportive Services:
- **Client is getting assistance from Badger Food Pantry; mental health counseling at Aurora clinic; transportation assistance (rides from CM to appointments and Walmart); help with cleaning supplies when we get donated items.**- **She’s receiving Food Share (decrease expected in March) and Social Security w/increase for 2023.**- **Was attending weekly survivor women’s group at Badger Healing Center. CM will work on referrals for dentist and eye doctor.**

Changes:
- **Client said she stopped attending survivor group bc she feels she’s getting what she needs through therapist.**- **Client said she wants to see an eye doctor and maybe a dentist, but she’s nervous about going to the dentist because it’s been many years.**

New Referrals:  **CM will research eye doctor and dentist.
2/17/23 CM sent text to client with phone # and info about ABC Dental and New Eyes program through 16th Street Clinic.**

Your Agency Name

CoC Program Annual Assessment Form

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Case Manager Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Project Start Date: **\_\_\_\_\_\_\_\_\_\_\_\_**

Current Supportive Services:

Changes:

New Referrals: