



ACP Brief Contacts

Name: _____ Telephone Number: _____ Date of Phone Call: _____

Children: Yes _____ No _____

Age/Grade	School	Comments

Person Receiving Call: _____ Social Worker Designated: _____

To Be Filled Out By Social Worker

Date Contacted: _____

Housing Situation: Shelter D/U Hotel/Motel Stable Other (specify) _____

ACP Client: Yes No Former

Service Requested:

- Academic Support Clothing/Uniforms Health Services Shelter
- ACP Program Counseling Holiday Sponsorship Transportation
- Basic Needs Employment Housing
- Childcare Financial Assistance None

Other _____

Service Provided:

Referral to community agency (specify)

Utilized ACP Resources

Pending
 Unable to meet need

Follow Up:

Eligible for ACP services Date Assessment Scheduled: _____ Time: _____
 Ineligible for ACP services Reason: _____

Additional Comments: _____

