Trinity County Health and Human Services
Employment Services Dept. Housing Support Program Plan

Case Name: _____

Case Number: _____

Housing Support Program Participant: _____

I understand that my participation in the CalWORKs Housing Support Program (HSP), is voluntary. However, the activities listed in this plan will help me achieve my desired housing goals. I understand that services through HSP may be interrupted or stopped based on the following; if I choose not to participate in HSP or in the activities listed in this plan, funding for the HSP program is no longer available, or if I am no longer eligible to CalWORKs. I may not be eligible to HSP services if I make false or misleading statements in order to get HSP. I also understand that if I am a mandatory Welfare-to-Work participant, I may be asked to engage in Welfare to Work services and/or Family Stabilization services in order to help me achieve my housing goals and/or maintain housing stability.

Housing Support Program Activities

HSP ACTIVITY:		HSP ACTIVITY LOCATION:
ACTIVITY BEGINS:	ACTIVITY EXPECTED TO END:	ACTIVITY SCHEDULE:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
VERIFICATION DUE DATE:		

HSP ACTIVITY:		HSP ACTIVITY LOCATION:
ACTIVITY BEGINS:	ACTIVITY EXPECTED TO END:	ACTIVITY SCHEDULE:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
VERIFICIATION DUE DATE:		

HSP ACTIVITY:		HSP ACTIVITY LOCATION:
ACTIVITY BEGINS:	ACTIVITY EXPECTED TO END:	ACTIVITY SCHEDULE:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
VERIFICATION DUE DATE:		

HSP ACTIVITY:		HSP ACTIVITY LOCATION:
ACTIVITY BEGINS:	ACTIVITY EXPECTED TO END:	ACTIVITY SCHEDULE:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
ACTIVITY GOAL:		RESPONSIBLE PARTY:
VERIFICATION DUE DATE:		

Housing Support Program Supportive Services

The following supportive services are necessary in meeting my housing goals.

Ancillary Supportive Services

1.
2.
3.
4.

Certification:

I certify that I have read (or had read and explained to me) and understand the activities and supportive services outline in my Housing Support Plan.

Participant Signature Date Participant Signature Date

Worker Signature Date

❑ Additional Comments:

County Use Only:

Program Status:

❑ Approved

❑ Denied Denial Reason: _____

Case Approval Status (list type):

❑ Federal: _____

❑ Non-Federal: _____

❑ Non-MOE: _____

Worker initials: _____