

CASE MANAGER NAME AND PHONE NUMBER: *[Delete if not applicable]*

PROGRAM(S): *[Delete if not applicable]*

CASE MIX: *[Delete if not applicable]*

PERSONAL CARE ASSISTANCE (PCA) HOURS/HOME CARE RATING: *[Delete if not applicable]*

CONSUMER SUPPORT GRANT (CSG) AMOUNT: *[Delete if not applicable]*

DATE THIS DOCUMENT WAS MAILED:

STRENGTHS, ROUTINES, & DREAMS:

SUPPORTS DISCUSSED: