

FILE #: _____

RISE Disaster Case Management Consortium
Disaster Recovery Partnership Plan

Client Name: _____ **Case Manager:** _____

Date Initiated: _____

Level of Contact: weekly bi-weekly
 monthly as needed

Next Review Date: _____

GOAL: _____ **Target Date:** _____

Areas of Service: **HWB-P** Health & Well-being Physical; **HWB-M** Health & Well-being Mental; **HWB-S** Health & Well-being Spiritual; **HO**-Housing; **FO**-Food; **US**-Utilities; **FIN**-Financial; **EMP**-Employment; **TR**-Transportation; **Y**-Youth & Children; **AD**-Aged / Disabled; **ED**-Education; **LEG**-Legal; **BR**- Benefits Restoration; **CL**-Clothing; **FU**-Furniture; **LA**-language; **OT**-Other-Specify: _____

Area of Service	Objectives	Action Steps	Responsible Person	Target Date	Date Met	Outcome

FILE #: _____

RISE Disaster Case Management Consortium
Disaster Recovery Partnership Plan
(continued)

Area of Service	Objectives	Action Steps	Responsible Person	Target Date	Date Met	Outcome

FILE #: _____

RISE Disaster Case Management Consortium
Disaster Recovery Partnership Plan
(concluded)

Area of Service	Objectives	Action Steps	Responsible Person	Target Date	Date Met	Outcome

Client Signature: _____

Date: _____

Case Manager Signature: _____

Date: _____

Reviewed by Supervisor: _____

Date: _____

**This is not a legally binding document. It is a blueprint for assistance and may be revised at any time at the request of the client or case manager. Copy is provided to client.*