CATHOLIC CHARITIES OF SOUTHEAST TEXAS

Disaster Recovery Partnership Plan

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

Category(s) of Impact: ☐ Displaced Resident ☐ Physical Injury ☐ Income Loss ☐ Deployed In Emergency Response ☐ Death of Sig. ☐ Other

Next Review Date:_____ Level of Contact: ☐ Monthly ☐ Weekly ☐ Bi-Weekly ☐ As Needed

GOAL:_____

Area of Service: **HWB-P** Health & Well-being Physical HWB-**M** Health & Well-being Mental Health **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 **Other**-Specify

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

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Disaster Recovery Partnership Plan

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

Client Signature: _____ Date:_____

Worker Signature: _____ Date: _____

Reviewed by Supervisor: _____ Date: _____