Austin Public Health
PREVENT. PROMOTE. PROTECT.

STSH Tracking Worksheet

Form K2

Client Name and/or ID Number: _____ **Payment Cap:** _____

Housing Case Manager Name: _____ **Time Cap:** _____

Briefly certify that no other temporary shelters were available and that each assisted facility provided temporary shelter to no more than 50 households at one time. Justify why each stay is necessary for short- and long-term housing stability.

Instructions: Column 1 indicates the stay. Enter the type of facility for each stay in Column 2. Enter the actual necessary minimum costs and the amount of STSH expended on those costs in Columns 3 and 6. Enter the check-in and check-out dates in Columns 4 and 5. Column 7 calculates the number of nights assisted.

Notes: (1) STSH assistance may not be provided for costs accrued in excess of 60 nights. If the Project Sponsor uses a Payment and/or Time Cap, the total STSH assistance cannot exceed the Cap. If a Cap is reached, the assistance is attributable to the entire 60-night period. The 60-night limit always supersedes an established Cap. (2) If paying other eligible costs for use or occupancy of the facility, add them to the respective Actual column and Stay row. (3) For each stay, obtain an invoice or ledger from the owner/vendor to correctly attribute actual costs to the correct stays. (4) Formulas report an unduplicated number of nights assisted. Total Nights Assisted assumes HOPWA is the payer of last resort.

1	2	3	4	5	6	7
Stays	Type of Facility	Actual Cost	Check-in Date	Check-out Date	STSH Payment	Nights
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total						

Summary

		Six-month period start date:
		Six-month period end date:
FBHA Reporting Category:	a. STSH	Next six-month period cannot start until:
TOTAL STSH EXPENDED:		**TOTAL NIGHTS ASSISTED:**

January	February	March	April	May	June

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July	August	September	October	November	December