

Client Food Assistance and Incentive Gift Card Receipt Log

Health District _____ Date _____

This form serves as confirmation that the client has received the gift card(s) listed below. Upon receipt/distribution, both the Nurse Case Manager/designee and the client are required to sign.

Card Number(s)	Card Amount	Date	Client Initials	LHD initials	<u>NCM bought food</u>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>
	\$				<input type="checkbox"/>

Client Name Signature

Nurse Case Manager/Designee Name Signature