

### Disaster Client Intake

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First Name: \* \_\_\_\_\_  
Middle: \_\_\_\_\_  
Last Name: \* \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Gender:  Male  
 Female  
 Transgendered Female to Male  
 Transgendered Male to Female  
 Other  
 Don't Know  
 Refused  
Ethnicity:  Hispanic/Latino  
 Non-Hispanic/Latino  
 Don't Know  
 Refused  
Race: \*

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Pre-Disaster Address - Please enter the client's address prior to the disaster.

Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_

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Shelter Location - If the client is staying in a disaster relief facility, choose which facility and enter the location within that facility the client is in.

Facility: \_\_\_\_\_  
Location In Facility: \_\_\_\_\_

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Other Location - If the client is not staying in a disaster relief facility, please enter where they are staying below.

Other Location: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Client Addresses**

Record the client's addresses using the form below.

2 records found.

Address Type	Address	Address2	City/State/Zip Code	Begin Date	End Date	Primary Phone
<input type="checkbox"/> Current Mailing <input type="checkbox"/> Previous Mailing <input type="checkbox"/> Residential <input type="checkbox"/> Last Permanent Address	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Temporary <input type="checkbox"/> Emergency <input type="checkbox"/> Transitional <input type="checkbox"/> Permanent Supportive <input type="checkbox"/> Summer	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Current Mailing <input type="checkbox"/> Previous Mailing <input type="checkbox"/> Residential <input type="checkbox"/> Last Permanent Address	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Temporary <input type="checkbox"/> Emergency <input type="checkbox"/> Transitional <input type="checkbox"/> Permanent Supportive <input type="checkbox"/> Summer	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Current Mailing <input type="checkbox"/> Previous Mailing <input type="checkbox"/> Residential <input type="checkbox"/> Last Permanent Address	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Temporary <input type="checkbox"/> Emergency <input type="checkbox"/> Transitional <input type="checkbox"/> Permanent Supportive <input type="checkbox"/> Summer	_____	_____	_____	_____	_____	_____

Add Lines \_\_\_\_\_

## Applications

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Please fill out the form below to create a new application. You will be required to select the associated Program that the client is applying for.

Application Date: \* \_\_\_\_\_

Program: \* 2014- WashingtonCO

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### Eligibility Status

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Program Eligibility Determination: Passed

Eligibility Determination Details: The application passed the eligibility criteria.

Eligibility Status: \*  Pending - Financial Determination  
 Ineligible - Not Overridden  
 Ineligible - Overridden  
 Eligible

### Housing Assessment

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Please fill out the Housing Assessment.

Assessment Date: \_\_\_\_\_

Where did client live pre-disaster?: \*

In the disaster, was client home damaged or affected?:

- Yes
- No
- Don't Know
- Refused

Is client able to access the home?:

- Yes
- No
- Don't Know
- Refused

Does client consider home liveable or inhabitable?:

- Yes
- No
- Don't Know
- Refused

Client Damage Rating:

- Not Damaged
- Minor
- Major
- Destroyed
- Client Doesn't Know
- Refused

Was client relocated/evacuated?:

- Yes
- No
- Don't Know
- Refused

Do all of client's utilities work?:

- Yes
- No
- Don't Know
- Refused

Details of Disaster Impacts to Home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pre-disaster housing insurance status:  
Details of insurance information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8 records found.

Referral Status*	Service	Provider Name*	Telephone Street City State	Zip Code
<hr/>				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Emergency Housing	_____		
<input type="checkbox"/> Resource Not Available				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Housing Assistance	_____		
<input type="checkbox"/> Resource Not Available				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Housing Bednight	_____		
<input type="checkbox"/> Resource Not Available				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Housing Placement	_____		
<input type="checkbox"/> Resource Not Available				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Housing Reservation	_____		
<input type="checkbox"/> Resource Not Available				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Tarp / Blue Roof	_____		
<input type="checkbox"/> Resource Not Available				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Temporary Housing and Other Financial Aid	_____		
<input type="checkbox"/> Resource Not Available				
<input type="checkbox"/> Referral Made				
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Transitional Housing	_____		
<input type="checkbox"/> Resource Not Available				

### Pre-Disaster Financial Assessment

Indicate below the client's sources of **monthly Pre-Disaster** income/benefits.

Assessment Date: \* \_\_\_\_\_

Income Received: \*  No  
 Yes  
 Don't Know  
 Refused

Non-cash Benefits: \*  No  
 Yes  
 Don't Know  
 Refused

No data  
 Income Group:  Cash Income  
 Non-cash Benefit

27 records found.

<input type="checkbox"/> Type	Description	Monthly Amount
<input type="checkbox"/> Earned Income (i.e., employment income)	_____	_____
<input type="checkbox"/> Unemployment Insurance	_____	_____
<input type="checkbox"/> Supplemental Security Income (SSI)	_____	_____
<input type="checkbox"/> Social Security Disability Income (SSDI)	_____	_____
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) (Food Stamps)	_____	_____
<input type="checkbox"/> Veteran's Disability Payment	_____	_____
<input type="checkbox"/> Private Disability Insurance	_____	_____
<input type="checkbox"/> Worker's Compensation	_____	_____
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	_____	_____
<input type="checkbox"/> General Assistance	_____	_____
<input type="checkbox"/> MEDICAID	_____	_____
<input type="checkbox"/> Retirement income from Social Security	_____	_____
<input type="checkbox"/> Veteran's Pension	_____	_____
<input type="checkbox"/> Other Pension	_____	_____
<input type="checkbox"/> Child Support	_____	_____
<input type="checkbox"/> Alimony or other spousal support	_____	_____
<input type="checkbox"/> MEDICARE	_____	_____

Count/Total Monthly Income:                      0                      \$0.00

<input type="checkbox"/> Type	Description	Monthly Amount
<input type="checkbox"/> Other Income		
<input type="checkbox"/> State Children's Health Insurance Program		
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		
<input type="checkbox"/> Veteran's Administration Medical Services		
<input type="checkbox"/> TANF Child Care Services		
<input type="checkbox"/> TANF Transportation Services		
<input type="checkbox"/> Other TANF-funded Services		
<input type="checkbox"/> Section 8, Public Housing, or Other Ongoing Rental Assistance		
<input type="checkbox"/> Other Source		
<input type="checkbox"/> Temporary rental assistance		
Count/Total Monthly Income:	0	\$0.00

### Post-Disaster Financial Assessment

Indicate below the client's sources of **monthly Post-Disaster** income/benefits.

Assessment Date: \* \_\_\_\_\_

Income Received: \*  No  
 Yes  
 Don't Know  
 Refused

Non-cash Benefits: \*  No  
 Yes  
 Don't Know  
 Refused

No data  
 Income Group:  Cash Income  
 Non-cash Benefit

27 records found.

<input type="checkbox"/> Type	Description	Monthly Amount
<input type="checkbox"/> Earned Income (i.e., employment income)	_____	_____
<input type="checkbox"/> Unemployment Insurance	_____	_____
<input type="checkbox"/> Supplemental Security Income (SSI)	_____	_____
<input type="checkbox"/> Social Security Disability Income (SSDI)	_____	_____
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) (Food Stamps)	_____	_____
<input type="checkbox"/> Veteran's Disability Payment	_____	_____
<input type="checkbox"/> Private Disability Insurance	_____	_____
<input type="checkbox"/> Worker's Compensation	_____	_____
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	_____	_____
<input type="checkbox"/> General Assistance	_____	_____
<input type="checkbox"/> MEDICAID	_____	_____
<input type="checkbox"/> Retirement income from Social Security	_____	_____
<input type="checkbox"/> Veteran's Pension	_____	_____
<input type="checkbox"/> Other Pension	_____	_____
<input type="checkbox"/> Child Support	_____	_____
<input type="checkbox"/> Alimony or other spousal support	_____	_____
<input type="checkbox"/> MEDICARE	_____	_____
Count/Total Monthly Income:	0	\$0.00



<input type="checkbox"/> Type	Description	Monthly Amount
<input type="checkbox"/> Other Income	_____	_____
<input type="checkbox"/> State Children's Health Insurance Program	_____	_____
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	_____	_____
<input type="checkbox"/> Veteran's Administration Medical Services	_____	_____
<input type="checkbox"/> TANF Child Care Services	_____	_____
<input type="checkbox"/> TANF Transportation Services	_____	_____
<input type="checkbox"/> Other TANF-funded Services	_____	_____
<input type="checkbox"/> Section 8, Public Housing, or Other Ongoing Rental Assistance	_____	_____
<input type="checkbox"/> Other Source	_____	_____
<input type="checkbox"/> Temporary rental assistance	_____	_____
Count/Total Monthly Income:	0	\$0.00

## Pre-Disaster Employment Assessment

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Check the appropriate employment status for immediately prior to the disaster. If the client is employed, record the hours worked in the week prior to assessment, and select the tenure of the employment position. If the client is not employed, indicate if the client is looking for work.

Assessment Date: \* \_\_\_\_\_

Employed?: \*  Yes  
 No  
 Don't Know  
 Refused

Looking for Work: \*  Yes  
 No  
 Don't Know  
 Refused

## Post-Disaster Employment Assessment

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Check the appropriate employment status immediately following the disaster. If the client is employed, record the hours worked in the week prior to assessment, and select the tenure of the employment position. If the client is not employed, indicate if the client is looking for work.

Assessment Date: \* \_\_\_\_\_

Employed?: \*  Yes  
 No  
 Don't Know  
 Refused

Looking For Work: \*  Yes  
 No  
 Don't Know  
 Refused

### FEMA / SBA Sequence of Delivery

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Does client have FEMA registration number?:

Yes  
 No  
 Don't Know  
 Refused

Manage the progress of various loan-related activities

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<input type="checkbox"/> Activity	Progress	Entry Date	Start Date	Completion Date
<input type="checkbox"/> <input type="checkbox"/> Client has not received or does not know <input type="checkbox"/> Client received envelope from SBA but threw away <input type="checkbox"/> Client has submitted SBA application <input type="checkbox"/> Client has been approved for SBA loan <input type="checkbox"/> Client has submitted claim for FEMA Individual Assistance <input type="checkbox"/> Client has received Non-Comp Notice from FEMA IA <input type="checkbox"/> Client has received FEMA IA Benefit	<input type="checkbox"/> Complete <input type="checkbox"/> Incomplete <input type="checkbox"/> In Progress			

<input type="checkbox"/> Activity	Progress	Entry Date	Start Date	Completion Date
<input type="checkbox"/> Client has received Max Grant from FEMA				
<input type="checkbox"/> Client has applied for FEMA Other Needs Assistance				
<input type="checkbox"/> Client has received ONA				
<input type="checkbox"/> Client was denied for ONA				

Add Lines

Create Service Referrals for the client

Default Enrollment:  04/08/2015 - 2014- WashingtonCO

<input type="checkbox"/> Service*	Enrollment*	Units Of Measure*	Unit Value*	Units* Total
<input type="checkbox"/> <input type="checkbox"/> Assist with appeal for SBA denial	<input type="checkbox"/> 04/08/2015 - 2014- WashingtonCO	<input type="checkbox"/> Dollars		\$0.00
<input type="checkbox"/> Assist with completion of FEMA IA Application		<input type="checkbox"/> Minutes		
<input type="checkbox"/> Assist with completion of FEMA ONA Application		<input type="checkbox"/> Count		
<input type="checkbox"/> Assist with completion of SBA Loan Application		<input type="checkbox"/> Hours		
<input type="checkbox"/> Assist with FEMA IA denial				
<input type="checkbox"/> Assist with FEMA ONA denial				
<input type="checkbox"/> Assist with registration for FEMA/SBA Seq of Deliv				
<input type="checkbox"/> Obtain signed FEMA Disclosure release from client				
<input type="checkbox"/> Provide education regarding FEMA/SBA Seq of Deliv				

<input type="checkbox"/> Service*	Enrollment*	Units Of Measure*	Unit Value*	Units* Total
<input type="checkbox"/> Submit inquiry to FEMA IA Branch re: client's IA				
<input type="checkbox"/> Submit inquiry to FEMA IA Branch re: client's ONA				

Add Lines \_\_\_\_\_

**Health Insurance Sources**

Use the form below to create a point-in-time assessment of the individual's health insurance sources. Additionally, if this individual is not the head of household, you can click **Copy Insurance Sources** to copy insurance sources from the head of household's record. If the individual has at least one insurance source, you must identify one primary health insurance provider. If the individual does not have any insurance sources, simply click **Save and Close**.

Assessment Date: \* \_\_\_\_\_

<input type="checkbox"/> Type*	Is Primary	<input type="checkbox"/> Meds covered?	<input type="checkbox"/> DME covered?	Status*	Was this insurance lost as a result of the disaster?	What caused the insurance coverage to be lost?	Please provide reason	Start Date	End Date	Applied For Date
<input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Children's Health Insurance Program S-CHIP <input type="checkbox"/> Military Insurance <input type="checkbox"/> Other Public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pending / Applied <input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know <input type="checkbox"/> refused	<input type="checkbox"/> Place of employment totally destroyed <input type="checkbox"/> Loss of Employment <input type="checkbox"/> Employer Downsized <input type="checkbox"/> Client Relocated out of Service Area <input type="checkbox"/> Reduction of work hours <input type="checkbox"/> Disaster Caused Disability <input type="checkbox"/> Other				
<input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Children's Health Insurance Program S-CHIP <input type="checkbox"/> Military Insurance <input type="checkbox"/> Other Public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pending / Applied <input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know <input type="checkbox"/> refused	<input type="checkbox"/> Place of employment totally destroyed <input type="checkbox"/> Loss of Employment <input type="checkbox"/> Employer Downsized <input type="checkbox"/> Client Relocated out of Service Area <input type="checkbox"/> Reduction of work hours <input type="checkbox"/> Disaster Caused Disability <input type="checkbox"/> Other				

Add Lines \_\_\_\_\_

## Transportation Assessment

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### Transportation Assessment

Assessment Date: \_\_\_\_\_

What was the client's primary mode of transportation prior to the disaster? \*

- Privately owned vehicle or motorcycle
- Public transit
- Paratransit
- Carshare
- Ride with friends/family
- Walk
- Bike
- Other

Is this method of transportation still working for the client post-disaster? \*

- Yes
- No
- Don't Know
- Refused

Transportation Needs:

3 records found.

<input type="checkbox"/> Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Bus Pass	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Bus Tokens	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Transportation	_____					



### Food Assessment

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Please complete the assessment below.

Assessment Date: \_\_\_\_\_

Does client have enough food to feed all members of the household?:

Yes  
 No  
 Don't Know  
 Refused

Pre-Disaster, was client or any household members receiving:

Since the disaster, has client requested help with food from anyone?:

Yes  
 No  
 Don't Know  
 Refused

5 records found.

<input type="checkbox"/> Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Assistance with D-SNAP application	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral to community orgs for food needs	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral to mass care for immediate food needs	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Restoration of pre-disaster Meals on Wheels svc	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Social Services for WIC/SNAP	_____					



### Behavioral Health Assessment

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Please complete the Assessment below.

Assessment Date: \_\_\_\_\_ \*

Is client or anyone in the household in distress?:

Yes  
 No  
 Don't Know  
 Refused

Would client or anyone in the household like to speak to someone about coping with disaster-related distress?:

Yes  
 No  
 Don't Know  
 Refused

4 records found.

<input type="checkbox"/> Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Community clinical provider	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Crisis Counseling Program	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Disaster Distress Helpline	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Emergency behavioral health intervention	_____					

## Child and Youth Services assessment

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Please complete the Assessment below.

Assessment Date: \_\_\_\_\_

Prior to the disaster, was client's child in a child care or Head Start program? \*  Yes  
 No  
 Don't Know  
 Refused

If yes, were the services disrupted as a result of the disaster? \*  Yes  
 No  
 Don't Know  
 Refused

Does client currently have a need for child care? \*  Yes  
 No  
 Don't Know  
 Refused

Prior to the disaster did client get voucher assistance for child care? \*  Yes  
 No  
 Don't Know  
 Refused

If childcare is needed but child is not getting it, what are the barriers?:

Was client receiving child support payments before the disaster? \*  Yes  
 No  
 Don't Know  
 Refused

Are client's kids currently in school? \*  Yes  
 No  
 Don't Know  
 Refused

Since the disaster has your child missed any scheduled checkups or immunizations? \*  Yes  
 No  
 Don't Know  
 Refused

Does client have concerns about how his/her child is coping post-disaster? \*  Yes  
 No  
 Don't Know  
 Refused

8 records found.

<input type="checkbox"/> Referral Status*	Service	Provider Name*	Telephone Street City State Zip Code
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Assistance with registering child for school	_____	
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Childcare	_____	
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Head Start/Early Head Start	_____	
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral for child support services assistance	_____	
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral to Child Care and referral Agency	_____	
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral to Disaster Distress Helpline	_____	
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral to social services for TAN/CCDF app.	_____	
<input type="checkbox"/> Referral Made		_____	

<input type="checkbox"/> Referral Status*	Service	Provider Name*	Telephone Street City State	Zip Code
<input type="checkbox"/> Not Eligible	Referral to VOAD/community grp for school supplies			
<input type="checkbox"/> Resource Not Available				

### Clothing Assessment

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Please complete the Assessment below.

Assessment Date: \_\_\_\_\_

Did any of the household members lose clothing as a result of the disaster?:

Yes  
 No  
 Don't Know  
 Refused

Does client/family have useable clothing and shoes for work or school?:

Yes  
 No  
 Don't Know  
 Refused

Does client/family have cold-weather clothing (e.g., coats, hats, gloves):

Yes  
 No  
 Don't Know  
 Refused

Did client make a claim for the clothes with the insurance company?:

Yes  
 No  
 Don't Know  
 Refused

4 records found.

Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/> Referral Made	Assistance with FEMA ONA	_____					
<input type="checkbox"/> Not Eligible							
<input type="checkbox"/> Resource Not Available							
<input type="checkbox"/> Referral Made	Assistance with insurance claim/appeal	_____					
<input type="checkbox"/> Not Eligible							
<input type="checkbox"/> Resource Not Available							
<input type="checkbox"/> Referral Made	Laundry Assistance	_____					
<input type="checkbox"/> Not Eligible							
<input type="checkbox"/> Resource Not Available							
<input type="checkbox"/> Referral Made	Referral to faith-based/comm. org for clothing	_____					
<input type="checkbox"/> Not Eligible							

<input type="checkbox"/>	Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/>	Resource Not Available							



### Furniture and Appliances assessment

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Assessment Date: \_\_\_\_\_

Did client have furniture or home appliances destroyed in the disaster? \*  Yes  
 No  
 Don't Know  
 Refused

Did client have a claim for the furniture and appliance with your insurance? \*  Yes  
 No  
 Don't Know  
 Refused

Did client get replacement items from any nonprofit organizations? \*  Yes  
 No  
 Don't Know  
 Refused

Was client able to install replacement furniture and appliances in the home? \*  Yes  
 No  
 Don't Know  
 Refused

4 records found.

Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/> Referral Made	Assistance with FEMA ONA	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available							
<input type="checkbox"/> Referral Made	Assistance with install of new or removal of old	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available							
<input type="checkbox"/> Referral Made	Assistance with insurance claim/appeal	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available							
<input type="checkbox"/> Referral Made	Referral to faith-based/comm org for replacement	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available							

### Senior Services Assessment

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Please complete the Assessment below.

Assessment Date: \_\_\_\_\_

Prior to the disaster, was anyone in the household living in senior housing, assisted living, or in a nursing home?:

- Yes
- No
- Don't Know
- Refused

7 records found.

Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/> Referral Made	Assistance w/referral for long term care/placement	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Resource Not Available						
<input type="checkbox"/> Referral Made	Assistance with accessing VA benefits	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Resource Not Available						
<input type="checkbox"/> Referral Made	Assistance with LIHEAP application	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Resource Not Available						
<input type="checkbox"/> Referral Made	Home delivered meals (e.g. Meals on Wheels)	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Resource Not Available						
<input type="checkbox"/> Referral Made	Referral to Adult Day Health Care Center	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Resource Not Available						
<input type="checkbox"/> Referral Made	Referral to area agency on aging	_____					
<input type="checkbox"/> <input type="checkbox"/> Not Eligible	Resource Not Available						
	Referral to senior center	_____					

<input type="checkbox"/> Referral Status*	Service	Provider Name*	Telephone Street City State	Zip Code
<input type="checkbox"/> <input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available				

## Language Assessment

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Please complete the Assessment below.

Assessment Date: \_\_\_\_\_

Pre-Disaster, was client receiving language services?:

- Yes
- No
- Don't Know
- Refused

Client is currently having difficulty accessing services due to language concerns:


- Yes
- No
- Don't Know
- Refused

As a result of the disaster, client lost language services:

- Yes
- No
- Don't Know
- Refused

2 records found.

<input type="checkbox"/> Referral Status* Service	Provider Name*	Telephone	Street	City	State	Zip Code
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Non-profit community language resources	_____				
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	State language services	_____				

 Does the client require Legal Services or Referral

Does the client require Legal Services or Referrals?

yes

no

### Legal Referral Services

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Please select from the Disaster-related Legal Referral Services available below.

3 records found.

<input type="checkbox"/>	Referral Status*	Service	Provider Name*	Telephone Street City State	Zip Code
<input type="checkbox"/>	<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Assistance identifying private legal counsel	_____		
<input type="checkbox"/>	<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral to Disaster Legal Services Program	_____		
<input type="checkbox"/>	<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource Not Available	Referral to Legal Aid	_____		

## FEMA Tier Assignment

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Please select the appropriate Tier for the Client. To see a more in-depth explanation of the Tiers, hover over the question mark icon.

Assessment Date: \_\_\_\_\_

FEMA Tier System definitions:

- \*  Tier 1: Immediate Needs Met
- Tier 2: Some Remaining Unmet Needs or in Current Rebuild/Repair Status
- Tier 3: Significant Unmet Needs
- Tier 4: Immediate and Long-Term Unmet Needs