Disaster Client Intake

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: *

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

Address:

Address 2:

Zip Code:

City:

State:

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:

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
☐	☐ Current Mailing ☐ Previous Mailing ☐ Residential ☐ Last Permanent Address ☐ Temporary ☐ Emergency ☐ Transitional ☐ Permanent Supportive ☐ Summer	________	________	________, ____ ____	________	________	________
☐	☐ Current Mailing ☐ Previous Mailing ☐ Residential ☐ Last Permanent Address ☐ Temporary ☐ Emergency ☐ Transitional ☐ Permanent Supportive ☐ Summer	________	________	________, ____ ____	________	________	________
☐	☐ Current Mailing ☐ Previous Mailing ☐ Residential ☐ Last Permanent Address ☐ Temporary ☐ Emergency ☐ Transitional ☐ Permanent Supportive ☐ Summer	________	________	________, ____ ____	________	________	________

Add Lines ______

Applications

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

Eligibility Status

Program Eligibility Determination: Passed

Eligibility Determination Details: The application passed the eligibility crieria.

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

Housing Assessment

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
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Emergency Housing						
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Housing Assistance						
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Housing Bednight						
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Housing Placement						
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Housing Reservation						
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Tarp / Blue Roof						
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Temporary Housing and Other Financial Aid						
☐ Referral Made ☐ ☐ Not Eligible ☐ Resource Not Available	Transitional Housing						

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.

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

☐ Type	Description	Monthly Amount
☐ Other Income		
☐ State Children's Health Insurance Program		
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		
☐ Veteran's Administration Medical Services		
☐ TANF Child Care Services		
☐ TANF Transportation Services		
☐ Other TANF-funded Services		
☐ Section 8, Public Housing, or Other Ongoing Rental Assistance		
☐ Other Source		
☐ 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.

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

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

Pre-Disaster Employment Assessment

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

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

Does client have FEMA registration number?:

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused

Manage the progress of various loan-related activities

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

☐ Activity	Progress	Entry Date	Start Date	Completion Date
☐ Client has received Max Grant from FEMA				
☐ Client has applied for FEMA Other Needs Assistance				
☐ Client has received ONA				
☐ Client was denied for ONA				

Add Lines _____

Create Service Referrals for the client

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

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

☐ Service*	Enrollment*	Units Of Measure*	Unit Value*	Units* Total
☐ Submit inquiry to FEMA IA Branch re: client's IA				
☐ 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 indivdiual 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: * _____

☐ Type*	Is Primary	☐ Meds covered?	☐ 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
☐ Private ☐ Medicare ☐ Medicaid ☐ State Children's Health Insurance Program S-CHIP ☐ Military Insurance ☐ Other Public	☐	☐	☐	☐ Pending / Applied ☐ Active ☐ Inactive	☐ yes ☐ no ☐ don't know ☐ refused	☐ Place of employment totally destroyed ☐ Loss of Employment ☐ Employer Downsized ☐ Client Relocated out of Service Area ☐ Reduction of work hours ☐ Disaster Caused Disability ☐ Other				
☐ Private ☐ Medicare ☐ Medicaid ☐ State Children's Health Insurance Program S-CHIP ☐ Military Insurance ☐ Other Public	☐	☐	☐	☐ Pending / Applied ☐ Active ☐ Inactive	☐ yes ☐ no ☐ don't know ☐ refused	☐ Place of employment totally destroyed ☐ Loss of Employment ☐ Employer Downsized ☐ Client Relocated out of Service Area ☐ Reduction of work hours ☐ Disaster Caused Disability ☐ Other				

Add Lines _____

Transportation Assessment

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.

☐ Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
☐ ☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Bus Pass						
☐ ☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Bus Tokens						
☐ ☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Transportation						

Food Assessment

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.

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

Behavioral Health Assessment

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.

☐ Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Community clinical provider						
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Crisis Counseling Program						
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Disaster Distress Helpline						
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Emergency behavioral health intervention						

Child and Youth Services assessment

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.

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

☐ Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
☐ Not Eligible ☐ Resource Not Available	Referral to VOAD/community grp for school supplies						

Clothing Assessment

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
☐ ☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance with FEMA ONA						
☐ ☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance with insurance claim/appeal						
☐ ☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Laundry Assistance						
☐ ☐ Referral Made ☐ Not Eligible	Referral to faith-based/comm. org for clothing						

☐ Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
☐ Resource Not Available							

Furniture and Appliances assessment

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
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance with FEMA ONA	_____					
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance with install of new or removal of old	_____					
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance with insurance claim/appeal	_____					
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Referral to faith-based/comm org for replacement	_____					

Senior Services Assessment

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
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance w/referral for long term care/placement						
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance with accessing VA benefits						
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance with LIHEAP application						
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Home delivered meals (e.g. Meals on Wheels)						
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Referral to Adult Day Health Care Center						
☐	☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Referral to area agency on aging						
		Referral to senior center						

☐ Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
☐ ☐ Referral Made ☐ Not Eligible ☐ Resource Not Available							

Language Assessment

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.

☐ Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Non-profit community language resources	_____					
☐ Referral Made ☐ Not Eligible ☐ 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

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

3 records found.

☐ Referral Status*	Service	Provider Name*	Telephone	Street	City	State	Zip Code
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Assistance identifying private legal counsel						
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Referral to Disaster Legal Services Program						
☐ Referral Made ☐ Not Eligible ☐ Resource Not Available	Referral to Legal Aid						

FEMA Tier Assignment

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