

Senior Services Assessment

Assessment Date: _____

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

Yes Don't know
 No Refused

Referral Status	Referral	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 accessing VA benefits	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource not available	Assistance with LIHEAP application	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource not available	Home delivered meals (e.g., Meals on Wheels)	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource not available	Referral to Adult Day Health Care Center	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource not available	Referral to area agency on aging	_____					
<input type="checkbox"/> Referral Made <input type="checkbox"/> Not Eligible <input type="checkbox"/> Resource not available	Referral to senior center	_____					