Access to Behavioral Health Assessment

Assessment Date: _____

Is client or anyone in the household in distress?

____Yes ____Don't know

____No

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

___Yes ____Don't know

____No

Would client like a referral for relational stress or for safety issues?

____Yes _____No

Referral Status	Referral	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	_____					

All needs identified in this assessment are self-reported by the client