

Access to Behavioral Health Assessment

Assessment Date: _____

Is client or anyone in the household in distress?

Yes Don't know

s

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
<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	_____					