

DREXEL UNIVERSITY DORNSIFE SCHOOL OF PUBLIC HEALTH  
DISASTER PREPAREDNESS HOME ASSESSMENT SCREENING TOOL

Study Number\_\_\_\_  
Date of Assessment \_\_\_\_\_  
Time Started \_\_\_\_\_  
Time Completed \_\_\_\_\_  
Language: English  Spanish   
Team Members:  
SW  CHW  Medical Equipment Provider   
American Red Cross Responder   
Initial Visit  Follow Up Visit

Form approved  
OMB 0920-1154  
Exp. 1/31/2023

*Please note this tool will be used in electronic format with question-branching logic. For example, we will only ask the caregiver questions related to oxygen if the child is on oxygen.*

**Section 1 – DIAGNOSTIC DEMOGRAPHICS**

In this first section I'll be asking you some medical information relating to your child's medical diagnostic and medical needs. For each of the questions below, when I ask about a medical diagnosis, I would like to know if that diagnosis has been made by a medical professional.

**1) Does your child have a developmental disability?  Yes  No**

[If yes] What is your child's diagnosis (review choices with caregiver)?

- a) Autism spectrum disorder  Yes  No
- b) Intellectual disability  Yes  No
- c) Learning disability  Yes  No
- d) Communication challenges  Yes  No
  - i) Verbal Yes/No
  - ii) Uses an assistive communication device yes/no (If yes, which type)
  - iii) Describe any other challenges with communication\_\_\_\_\_
- e) Deaf or hard of hearing
- f) Other  Yes  No: \_\_\_\_\_

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**2) Does your child have a vision impairment that is not significantly improved by corrective lenses? € Yes € No**

a) [If yes] Does your child use corrective lenses? € Yes € No

**3) Does your child have a mental health diagnosis(es)? € Yes € No**

[If yes] What is your child's mental health diagnosis (review choices with caregiver)?

a) Anxiety € Yes € No

b) Depression € Yes € No

c) Bipolar € Yes € No

d) Post-Traumatic Stress Disorder € Yes € No

e) Obsessive Compulsive Disorder € Yes € No

f) Behavioral Concerns € Yes (Describe) \_\_\_\_\_ € No

g) ADHD € Yes € No

h) Other € Yes € No: \_\_\_\_\_

**4) I am now going to read through a list of medical conditions. Please let me know if your child has been diagnosed with any of the following:**

a) Cerebral Palsy € Yes € No

b) Prematurity with complications € Yes € No

i) If yes, gestational age \_\_\_\_\_

c) Genetic syndrome € Yes € No

If yes, is the syndrome any of the following:

i) A metabolic condition € Yes € No

ii) Down syndrome € Yes € No

iii) Fetal Alcohol Spectrum Disorder € Yes € No

iv) Other € Yes € No \_\_\_\_\_

d) Epilepsy or seizures € Yes € No

e) Diabetes € Yes € No

f) Asthma € Yes € No

g) Hemophilia € Yes € No

h) Chronic renal disease € Yes € No

i) Congenital heart disease or cardiac diagnosis € Yes € No

j) Chronic lung disease or malformation € Yes € No

k) Hypertension € Yes € No

l) Muscular Dystrophy € Yes € No

m) Spina Bifida € Yes € No

n) Sickle Cell Disease € Yes € No

o) Other € Yes € No: \_\_\_\_\_

- 5) **What do you consider your child's primary, or most significant diagnosis** (*populate if more than one is identified*)? \_\_\_\_\_
- a) Would you agree that this is also the most important, or challenging, diagnosis to consider in an emergency situation? If not, what diagnosis would be most challenging in an emergency? \_\_\_\_\_
- 6) **Is your child able to walk without any assistance?** € Yes € No
- a) [If no] Is your child able to walk with assistance?  
Yes € Please tell me what equipment your child uses to help him/her walk [ask i-viii]?  
No € [skip to B]  
[If yes] Wheelchair for longer distances € Yes € No
- i) Walker € Yes € No  
ii) Gait trainer € Yes € No  
iii) Assistive hand devices € Yes € No  
iv) Bracing arms or hand splints € Yes € No  
v) Bracing Legs (MAFOs, AFOS) € Yes € No  
vi) Stander € Yes € No  
vii) Other € Yes € No \_\_\_\_\_
- b) **[If no] Does your child use a wheelchair or does your child use a stretcher for support?**
- i) Wheelchair  
ii) Uses stretcher for support  
iii) Other € Yes € No \_\_\_\_\_
- 7) **Does your child have any special dietary needs?**
- i) Yes, Explain: \_\_\_\_\_  
ii) No
- 8) **Is your child on special formula?**
- i) Yes, list formula: \_\_\_\_\_  
ii) No
- 9) **Does your child require diapers for urine or stool?** € Yes € No
- If yes, check below
- i) Urinary € Yes € No  
ii) Stool or Fecal € Yes € No  
iii) If yes, do you have a 7 day emergency supply of diapers? € Yes € No
- 10) **Does your child take any medication every day, or as needed, such as when they are sick or in an emergency?** € Yes (answer below) € No
- a) Can you list those medications for me? \_\_\_\_\_

- i) Medication name # 1 (check one below) *Continue to populate for all medications*
  - (1) Chronic Medication (everyday)
  - (2) As needed, or emergency medication (when sick) \_\_\_\_\_
- b) How many medications (oral) \_\_\_\_\_
- c) How many medications (injected or other admin) \_\_\_\_\_
- d) Do you have a 7-day emergency supply of medicine available? € Yes € No
  - i) If no, why not? (check one)
    - (1) Not allowable by manufacturer
    - (2) Not covered by insurance
    - (3) Other \_\_\_\_\_
- e) Do any of your child's regular medications require refrigeration? € Yes € No
- f) Do you regularly check expiration dates on medication? € Yes € No

**11) Does the caregiver (s) have any special needs (such as a wheelchair, walker, oxygen tank, or vision or hearing impairment) that may make it difficult to ensure the family is safe in the event of an emergency?**

- € Yes, please list specific needs: \_\_\_\_\_
- € No

**SECTION 2-EQUIPMENT/ASSISTIVE TECHNOLOGY REQUIREMENTS**

*In this next section I'll be asking you about medical equipment or medical supplies that your child may need.*

**1. Does your child use any medical equipment or require any medical supplies?**

€ Yes- OK, does your child have a...*[ask about all potential equipment listed below]*

€ No

- a) Gastrostomy tube (GT) (also called a mickey or button) Yes No
  - i) Do you have an extra g-tube (or button) to replace the g-tube? Yes No
- b) Gastrojejunostomy tube (GJ) Yes No
  - i) Do you have an extra g-tube (or button) to replace the g-tube? Yes No
- c) Nasogastric (NG) tube Yes No
  - i) Do you have at least 1-2 extra feeding tubes? Yes No
- d) Nasojejunostomy (NJ) tube Yes No

*[If yes to a, b, c or d above- populate below questions]*

- e) Does your child use a feeding pump? Yes No
  - If yes:
    - i) Do you know how to convert tube feedings from the pump to gravity feeds?  
Yes No
    - ii) Do you have extra (7-day supply) of formula, in addition to your regular supply to feed via bolus? Yes No

- iii) Do you have syringes (7-day supply) in case of a power outage (to be used in place of the pump)? Yes No
  - f) Do you have extra (7-day supply) gravity (feeding) bags? Yes No
  - g) Do you have difficulty getting the formula you need for your child? Yes No
  - h) Do you have extra extension sets? Yes No
  - i) Does the family understand how to use the equipment (DME Assessment)?  
Yes  
No: If no-instruction provided € Yes € No
- 2) [If yes to a, b or c above- populate below questions] **Do you keep (or bring with you) the following in your travel bag?** (review all items below with caregiver)
- a) Feeding pump with power cord? € Yes € No [populate if yes to d above]
  - b) Extra g-tube kit? € Yes € No [populate for a and b]
  - c) Ph paper to verify tube placement? € Yes € No [populate for c above]
  - d) Spare feeding tube of correct size? € Yes € No [populate for c above]
  - e) Extension set? € Yes € No
  - f) Feeding bags? € Yes € No
  - g) Syringes (for feeding and any medication)? € Yes € No
  - h) Farrell bags? € Yes € No € N/A
  - i) Extra formula? € Yes € No
  - j) Medications? € Yes € No
  - k) Tape/tegaderm? € Yes € No [populate for c above]
  - l) Gloves? € Yes € No
  - m) Active copy of medication and feeding orders? € Yes € No
- 3) **Does your child require oxygen?** € Yes € No  
[If yes, medical equipment provider to work with caregiver and complete below items related to oxygen]
- a) Do you have full backup oxygen tanks  
Yes, how many? \_\_\_\_\_  
No
  - b) Is the key attached to oxygen tank? Yes No
  - c) Do you have a backup key? Yes No
  - d) Do you have a backup regulator? Yes No
  - e) Do you have a portable concentrator? Yes No
  - f) Do you have a backup nasal canula? Yes No
  - g) Type of Oxygen: \_\_\_\_\_ [Equipment provider to inspect and complete]  
Via: \_\_\_\_\_
  - i) Prescribed Rate: \_\_\_\_\_ (LPM) Actual \_\_\_\_\_ (LPM)
  - ii) Prescribed Patient Usage: \_\_\_\_\_ (Hours/Day) Actual Patient Usage:  
\_\_\_\_\_ (Hours/Day)
  - iii) RT Informed of discrepancies Yes No

- iv) Model/Manufacturer: \_\_\_\_\_  
Serial#: \_\_\_\_\_ Asset#: \_\_\_\_\_
- v) Hours \_\_\_\_\_ Analyzed F<sub>i</sub>O<sub>2</sub>: \_\_\_\_\_% Flow \_\_\_\_\_/\_\_\_\_\_
- vi) Within manufacturer limits Yes No  
    €Switched out
- vii) Alarms working (Sensor/Power) Yes No Switched out
- viii) Filters Clean (Air inlet/Bacteria) €Yes No Changed Re-instructed
- ix) Back-up cylinder full Yes No Changed Re-instructed
- x) Cylinders stored safely Yes No €Moved Re-instructed
- xi) Equipment Tagged/Clean Yes No Changed Re-instructed
- xii) Oxygen in use sign displayed Yes No Replaced Re-instructed
- xiii) Do any household members smoke? Yes No  
    (1) If yes, do they smoke inside the home?  
        Yes No If no, Reported to RT Re-instructed
- xiv) Family understands, can use all oxygen-related equipment  
    (1) If no-instruction provided Yes No

4) **Does your child have a tracheostomy?** Yes No

If yes, do you have the following items available and ready to go in a travel bag? [read all items below]

- a) Backup tracheostomy? Yes No
- b) Down size tracheostomy of appropriate size? Yes No
- c) Back up tracheostomy ties (ties prepared on the backup trach)? Yes No
- d) Portable suction machine with power cord? Yes No
- e) Extra batteries for suction machine? Yes No
- f) Suction canister with all connecting hoses Yes No
- g) Nasal aspirator? Yes No
- h) Appropriate sized suction catheters? Yes No
- i) All tubing and HMV if needed Yes No
- j) 10 saline bullets Yes No
- k) Syringe to inflate cuff, if needed Yes No
- l) Surgilube Yes No
- m) Pulse ox monitor with extra probes Yes No
- n) Ambu bag Yes No
- o) Nebulizer with circuit and tubing power cord Yes No
- p) Rescue inhalers, or nebulized airway medications with adaptor for trach Yes No
- q) Oxygen if appropriate with adaptor and tubing for trach Yes No
- r) Scissors Yes No
- s) Gloves Yes No
- t) Copy of care plan, active medications

- u) Family understands, can use equipment Yes No
  - i) If no – instruction provided Yes No
- 5) **Does your child require mechanical ventilation?** Yes No
- a) Do you keep the primary ventilator plugged in, or fully charged when not in use?  
Yes No
  - b) Do you have a backup ventilator? Yes No
  - c) Do you keep the backup ventilator plugged in or fully charged when not in use?  
Yes No
  - d) Are marine/lithium batteries available in case of long-term power outage? Yes No
  - e) Is a copy of your child’s ventilator settings in the above go-bag? Yes No
  - f) Does the family understand and able to use ventilator-related equipment Yes No
  - g) If no – instruction provided Yes No
- 6) **Does your child have a pulse oximetry machine?** Yes No
- a) Is the pulse oximetry machine portable? Yes No
  - b) Do you have backup batteries in your home for the pulse ox machine?  
Yes No
  - c) Do you have backup pulse ox probes Yes No
  - d) Does the family understand and know how to use the pulse ox? Yes No
  - e) If no – instruction provided Yes No
- 7) **Does your child use a CPAP, BiPAP or AVAPs machine?** Yes (check 1 below) No
- a) CPAP Machine
  - b) BiPAP machine
  - c) AVAPs machine
  - d) Do you receive a mask and tubing once every 3 months? Yes No [*populate for a -c above*]
  - e) Do you have a contingency plan from your child’s pulmonologist if the power where to go out and your child could not use the CPAP for one or more days? [*populate for a or b above*] Yes No
  - f) Do you keep the machine plugged in with backup batteries in case of a power outage? [*populate for c above*] Yes No
  - g) Do you have a copy of the physician orders for use? Yes No
- 8) **Does your child have an apnea monitor?** Yes, what type? \_\_\_\_\_ No
- a) Do you have enough (approx. 10-15) leads? Yes No
  - b) Do you have a belt? Yes No
  - c) Does the family understand and know how to use the equipment? Yes No
  - d) If no – instruction provided Yes No

- 9) **Does your child have a cardiac monitor?** Yes List type: \_\_\_\_\_ No  
a) Does the family understand and know how to use the equipment? Yes No  
b) If no – instruction provided Yes No

- 10) **Does your child have a pacemaker?** Yes No  
a) Does the family understand and know how to use the equipment? Yes No  
b) If no – instruction provided Yes No

11) **Does your child use a urinary catheter?**

Yes (check all that apply)

No

- a) Does your child get catheterized every 2-4 hours (intermittently)? Yes No  
b) Does your child use a foley catheter? Yes No

Do you have the following (read all below) [*Populate for a*]

- (1) Extra catheters (you should receive 150-180 per month) Yes No  
(2) 1 tube of lubricant per month Yes No  
(3) Bethadyne solution for cleaning if needed Yes No N/A  
(4) Gloves Yes No

Do you have the following (read all below) [*populate for b*]

- (5) Extra foleys (you should receive 30/month) Yes No  
(6) 5cc syringe, 4 per month Yes No  
(7) Urinary drainage bags, 4 bags per month Yes No  
(8) Gloves

12) **Does your child have an ostomy?** Yes No

If yes, do you have the following:

- a) Extra ostomy appliances (15-30 per month) Yes No  
b) 10 cc syringe (2 per month) Yes No  
c) 1 box of gauze per month Yes No  
d) Gloves Yes No

13) **Does your child have a central line (picc line or port) for infusion?** Yes No

- a) [If yes] Does your child get daily infusions? Yes No  
b) Do you keep your child's primary pump plugged in? Yes No  
c) Do you have a backup pump programmed? Yes No  
d) Do you keep the backup pump plugged in or fully charged when not in use? Yes No

14) **Does the caregiver have extra diabetic test strips?** € Yes € No [*populate only if positive for diabetes*]

- a) Does your child use insulin? € Yes € No  
b) Do you have a backup pump and medicine? € Yes € No



15) **Does your child have prescribed factor that you keep at home?** € Yes € No *[populate only if positive for hemophilia]*

a) If no, what is your safety plan in case of an emergency or trauma? \_\_\_\_\_

16) **Does your child have a nebulizer?** Yes No

a) Do you have two extra albuterol pumps available? Yes No

b) Do you have two extra spacers available? Yes No

c) Do you have extra nebulizer circuits and masks? Yes No

d) Do you have an asthma action plan? Yes No

e) Does the family understand and know how to use the equipment? Yes No

f) If no – instruction provided Yes No

17) **Does any of the above equipment (if checked) require:**

€ Power (to use or to charge) € Internet

€ Are flammable materials safely stored? Yes No

[If no] Proper storage procedures reviewed? Yes No

18) **Have you been unable to get the equipment needed to meet your child's healthcare needs?** (nebulizer, feeding pump, CPAP, suction devices are examples)

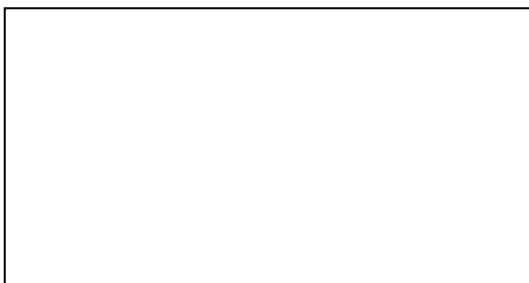
€ Yes, please explain: \_\_\_\_\_

€ No

|

***[Equipment provider to independently complete]***

Primary Equipment Location: \_\_\_\_\_ Floor \_\_\_\_\_ Room



Outlets Marked : XX # of outlets = \_\_\_\_\_

Doorway Marked : DD # of exits = \_\_\_\_\_

Window Marked : WW # of windows = \_\_\_\_\_

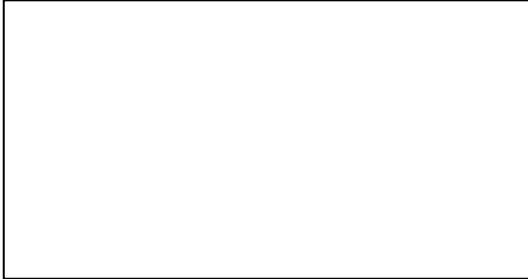
Bed / Crib Marked: BB

Other Electronics: \_\_\_\_\_

Other Appliances: \_\_\_\_\_

Approximate total amps \_\_\_\_\_

Secondary Equipment Location: \_\_\_\_\_ Floor \_\_\_\_\_ Room



Outlets Marked : XX # of outlets = \_\_\_\_  
 Doorway Marked : DD # of exits = \_\_\_\_  
 Window Marked : WW # of windows = \_\_\_\_  
 Bed / Crib Marked: BB  
 Other Electronics: \_\_\_\_\_  
 Other Appliances: \_\_\_\_\_  
 Approximate total amps \_\_\_\_\_

**EQUIPMENT ELECTRICAL REQUIREMENTS (see grid of amps listed)**

	Acceptable	Unacceptable	N/A
1. Amperage			type of service ____ amps
2. Outlets			total number in use ____
3. Grounding			Total number grounded ____
4. Circuit Breakers			
Labeled			Amps per breaker ____
5. Fuses labeled			Amps per fuse ____
6. Back-up Procedures			
Reviewed			_____

**Section 3- DESCRIPTION OF HOUSEHOLD ENVIRONMENT**

*[Equipment provider to complete with consultation from the caregiver as needed]*

1. Type of Housing € Single Family € Multi-Family Unit € Apartment
2. Number of floors in the home: Enter Number \_\_\_\_\_
3. Child/youth with special needs bedroom location (floor of home)
4. Stairs to bedroom € Yes € No
5. Stair glide present (if child non-ambulatory) € Yes € No
6. Ramp present outside home (if child non-ambulatory) € Yes € No

7. Child bed appropriate for special health care needs  
€ Yes, List type of specialty bed, if applicable: \_\_\_\_\_  
€ No
8. Is a patient lift needed? € Yes € No
9. Heat Yes No  
If yes, Gas € Electric € Space Heater € Other €
10. Air conditioning Yes No
11. Fans Yes # \_\_\_ No
12. Plumbing Yes No
13. Wheelchair/Handicap Accessible Yes No N/A
14. Hazard Free Access to Bathroom/tub/shower Yes No N/A
15. Structural Limitations Yes No(Describe) N/A
16. Obstacles to Safe Use/Mobility Yes(Describe) No N/A
17. Allergy Issues: \_\_\_\_\_
18. Infestations and/or need for exterminator: \_\_\_\_\_
19. Other Problems Identified: \_\_\_\_\_

*In this next section we are going to ask you some questions related to fire safety.*

1. Do you have any smoke alarms in your home? Yes No  
a) If yes, do you know the type of smoke alarm(s) in your home? € Yes € No  
€ 9 volt battery alarm  
€ 10 volt battery alarm  
€ Unsure
2. Do you have smoke alarms that light up (populate for deaf and hard of hearing residents)?  
€ Yes € No € N/A
3. Do you have a bed shaker alarm (populate for deaf and hard of hearing residents)?  
€ Yes € No € N/A
4. Do you test your smoke alarm once per month? € Yes € No
5. How many pre-existing smoke alarms does the household already have? Enter Number \_\_\_\_
6. How many pre-existing smoke alarms are working? Enter Number \_
7. Is there a smoke alarm on every floor of the home including the basement? € Yes € No
8. Do you have carbon monoxide detectors in your home? € Yes € No
9. Do you test your carbon monoxide detectors once per month? € Yes € No
10. Do you have carbon monoxide alarms that light up? (populate for deaf and hard of hearing residents) € Yes € No
11. Do you test your carbon monoxide detectors once per month? € Yes € No
12. How many pre-existing carbon monoxide detectors does the household already have?  
Enter Number \_\_\_\_

13. How many pre-existing carbon monoxide detectors are working? Enter Number \_
14. Is there a carbon monoxide detector on every floor of the home including the basement?  
€ Yes € No
15. Do you have a fire extinguisher(s) within your home or apartment unit, including any common areas? € Yes € No
- a) If yes, have you been trained on how to use the fire extinguisher? € Yes € No
- b) If yes, where did you receive the training? \_\_\_\_\_
16. Do you have flashlights in the home? € Yes € No
17. Do you check if they are working? € Yes € No
18. Are walking paths always free of obstructions, including furniture and equipment, so everyone can safely exit the building during an emergency? € Yes € No
19. Is anyone required to travel through a room that can be locked in case of an evacuation or fire? € Yes € No
20. Do all interior doors, windows or window bars other than fire doors, readily open from the inside without keys, tools, or special knowledge and require less than 5 pounds of force to unlatch and set the door in motion? € Yes € No
- a) If a key is required, is the key located near the door or window easily accessible to all residents? € Yes € No
21. Are any temporary/emergency escape paths clear of obstacles caused by construction or repair? € Yes € No

## **SECTION 5- EMERGENCY PLANNING**

### EVACUATION

In this next section, we will be asking you questions about preparing for different types of emergencies or disasters. When answering these questions, please keep in mind your child with special health care needs.

I'm now going to ask you questions about a type of disaster: Picture an emergency that would require you and your family to quickly leave your home to be safe. This could be a severe storm causing flooding or damage that has been predicted for your area, or a house fire.

[Visual Likert scale used with asking questions]

1. How likely do you believe an emergency that causes you to evacuate, such as a house fire or flood, will occur in the next 30 days?  
Would you say “1” not likely at all, or “5” extremely likely or a number in between?  
Enter Number \_\_\_\_
2. How likely do you believe an emergency that causes you to evacuate will occur in the next year?  
Would you say “1” not likely at all, or “5” extremely likely or a number in between?  
Enter Number \_\_\_\_
3. If an emergency causing you to evacuate were to occur, how serious do you think the impact would be to your family? Would you say “1” not serious at all, or “5” extremely serious or a number in between? Enter Number \_\_\_\_
4. How confident are you about your own family’s ability to manage or stay safe in an emergency like this? Would you say “5” extremely confident, “1” Not at all confident, or a number in between? Enter Number \_\_\_\_
5. Have you thought about planning for an emergency that would cause you to evacuate your home? € Yes, can you tell me a little more about that? \_\_\_\_\_ € No
6. Do you have an evacuation plan to leave your home if it becomes unsafe, due a disaster such as a house fire or flood, for example?  
€ Yes € No
  - a) If yes, do all members of the household know the plan? € Yes € No
  - b) Is the evacuation plan practiced within the home?  
€ Yes
    - (1) Is the plan practiced and updated or reviewed every 6 months? € Yes € No  
€ No
  - c) Does your evacuation plan include a meeting place identified where all family members know to meet? € Yes € No
  - d) Are healthcare professionals (home nurses, aids, therapists) in the home aware of the evacuation plan (only ask if service providers to come home)? € Yes € No € N/A
7. How confident do you feel that having an emergency plan, as described above, will make a positive difference in an emergency? Would you say “5” extremely confident, “1” Not at all confident, or a number in between? Enter Number \_\_\_\_
8. Do you have pets or animals you would need to evacuate with you? € Yes € No

- a) If yes, do you have an emergency supply of food to last 3 days? € Yes € No
  - b) If yes, is this a service animal or family pet?
    - € Service animal
    - € Family pet
9. Does your family have access to transportation to leave home, or a plan for transportation?  
€ Yes € No
10. Does the family have a place to go if they must leave home? (family, shelter, hospital, other)  
€ Yes € No
11. Do you know where to go to get information on emergency shelters?  
€ Yes € No
12. Does the family have a go-bag (sometimes referred to as ER bag) prepared?  
€ Yes € No
- a) If yes, what is in the go-bag? (prompt: medical supplies, medication, important information to grab and go?) List: \_\_\_\_\_
13. Does your family have a communication plan? (Prompt: a way to contact family members in an emergency, plan to meet up if separated, etc.) € Yes € No
14. Have you alerted the local 911 call center about [child's name] medical needs?  
€ Yes  
€ No  
€ N/A
15. Have you registered with a local/state special needs registry?  
€ Yes  
€ No  
€ N/A
16. Does the child/youth with special needs have an "About Me" folder/EIF form, or page that briefly explains all the most important medical and/or behavioral/sensory information about your child to someone who may not know him/her? € Yes € No
- a) If yes, does this include a list of medical professionals involved in your child's care, name of pharmacy, and contact numbers? € Yes € No
  - b) If yes, where do you keep this document? \_\_\_\_\_
17. Up-to-date medical care plan summary? € Yes € No

a) If yes, where do you keep this? \_\_\_\_\_

18. Does your child wear a medical alert bracelet? € Yes € No

SHELTER-IN-PLACE [Visual Likert scale used with asking questions]

Now we would like you to think of a different scenario when answering the next set of questions. Picture an emergency that would require you and your family to have to stay in your home for three or more days without leaving. This could happen due to a severe storm that causes flooding, downed trees, and at least one full day of power loss. This could also be our current situation of an infectious disease outbreak in the region.

19. How likely do you believe an emergency like this (requiring three or more days at home without leaving) will occur in the next 30 days?

Would you say “5” extremely confident, “1” Not at all confident, or a number in between?  
Enter Number\_\_\_\_\_

20. How likely do you believe an emergency like this (requiring three or more days at home without leaving) will occur in the next year?

Would you say “5” extremely confident, “1” Not at all confident, or a number in between?  
Enter Number\_\_\_\_\_

21. How serious do you think the impact from an event like this would be on your family?

Would you say “5” extremely serious, “1” Not serious at all, or a number in between?  
Enter Number\_\_\_\_\_

22. How confident are you about your family’s ability to stay safe at home during an emergency like this (lasting three or more days)?

Would you say “5” extremely confident, “1” Not at all confident, or a number in between?  
Enter Number\_\_\_\_\_

23. Have you thought about planning for an emergency that causes you to lose power, and your family is unable to leave your home for three or more days? € Yes € No

24. Have you tried to learn more or find information about this kind of emergency? € Yes € No

25. Does your family have an emergency kit (flashlight, can opener, etc.)? € Yes € No

a) [If yes] Have you reviewed or updated your emergency kit in the last 6 months?  
€ Yes € No

26. Does the family have an emergency supply of ready-to-eat food to last 3 days? € Yes € No

27. Does the family have an emergency supply of water? A recommended supply is one gallon per person per day for drinking and sanitation (for at least 3 days)? € Yes € No

28. Does your family have a back-up power plan? € Yes € No

If yes, specify below:

€ Generator

(1) If yes, instruction provided for safe use € Yes € No

€ Invertors

€ Batteries € Yes € No

€ Other (specify \_\_\_\_\_)

29. Have you experienced a disaster or emergency with your child before? € Yes € No

If yes, please specify \_\_\_\_\_

## SECTION 6- SOCIAL DETERMINANTS OF HEALTH

In this next section we would like to ask you about some of your more basic needs like food and housing. We understand that it can be hard to prepare for a possible disaster when there are things you are worried about or struggling with right now.

30. Does your family have social or community support (family, church, etc.) to rely on if an emergency were to occur? € Yes € No If yes, please choose: (check all that apply)

a) Extended family

b) Friends

c) Church or place of worship

d) Other community support (please list) \_\_\_\_\_

31. Is there someone in your home who doesn't have health insurance?

a) Yes

€ If yes, who \_\_\_\_\_

b) No

32. Have you received SSI or Medicaid for your child in the past year?

a) Yes

€ Are you currently receiving SSI or Medicaid for your child?

(1) Yes

(2) No

(a) Has it been denied in the past 90 days?

(i) Yes

(ii) No

b) No

€ Have you been denied for SSI or Medicaid for your child in the past 90 days?



- (1) Yes
- (2) No

33. Have you received Social Security benefits (SSI/SSD) for yourself in the past year?

a) Yes

€ Are you currently receiving SSI or Medicaid for yourself?

- (1) Yes
- (2) No

(a) Has it been denied in the past 90 days?

- (i) Yes
- (ii) No

b) No

€ Have you been denied for SSI or Medicaid for yourself in the past 90 days?

- (1) Yes
- (2) No

34. Have you received food stamps, WIC, cash assistance, or Temporary Assistance for Needy Families (TANF) in the past year?

a) Yes

€ Are you currently receiving food stamps, WIC, cash assistance, or Temporary Assistance for Needy Families (TANF)?

- (1) Yes
- (2) No

(a) Has it stopped?

- (i) Do you know why? If yes, please explain\_\_\_\_\_
- (ii) I don't know why

b) No

35. Within the past 3 months were you worried whether your food would run out before you had money to buy more?

- a) Often
- b) Sometimes
- c) Never

36. Are you having difficulty with getting the formula you need for your child (PediaSure, etc.)?

- a) Yes
- b) No
- c) N/A

37. Do you own or rent your home?

a) Own

€ Do you have homeowners insurance?

b) Rent

€ Do you have renters insurance?

38. What is your primary method of transportation when traveling with your child?

- a) Personal/Family vehicle
- b) Public Transit
- c) Walk
- d) Medical Transportation (van, ambulance, paratransit)
  - € Ambulance Transport
  - € Logisticare
- e) Other \_\_\_\_\_

39. Does your child with special needs live at another residence 1 or more nights per week?

- a) Yes
- b) No

40. Is there a telephone (landline or cellular) working and available at all times in case of an emergency?

- a) Yes
- b) No

41. Have you had trouble paying for your utilities (such as gas/water/electric/phone) in the last 12 months?

- a) Yes
  - € If yes, what utility bills? \_\_\_\_\_
- b) No
- c) Decline

42. Do you have difficulty getting home repairs (mold, rodents, and leaks)?

- a) Yes
  - € If yes, what repairs? \_\_\_\_\_
- b) No

43. Do you have issues in your home with rodent, insects, or other pests? € Yes € No

44. Do you have any difficulty making your home more accessible for your child with special needs?

- a) Yes
  - € If yes, what modifications have been challenging? \_\_\_\_\_
- b) No
- c) Does not apply

45. [If you rent] In the past 30 days, has your landlord threatened to evict you or turn off utilities?
- a) Yes
  - b) No
  - c) Decline
46. Are you worried about not having a permanent home to stay in or that you might become homeless?
- a) Yes
  - b) No
  - c) Decline
47. Are you afraid you might be hurt by a partner or family member?
- a) Yes
  - b) No
  - c) Decline
48. Over the past two weeks, how often have you felt down, depressed, or hopeless?
- a) Often
  - b) Sometimes
  - c) Never
  - d) Decline
49. Does the primary caregiver have a reliable backup caregiver skilled in caring for the child's specific health care needs?
- a) Yes
    - € Who is that person? \_\_\_\_\_
  - b) No
50. What is your greatest strength as a caregiver? \_\_\_\_\_