**Narrative of Changes Table**

*The purpose of the Narrative of Changes Table is to demonstrate changes to a collection since the previous approval.*

Collection Title: Disaster Assistance Registration

OMB Control No.: 1660 – 0002

Current Expiration Date: 8/31/2022

Collection Instrument(s):

FEMA Form 009-0-1T (English) Tele-Registration, Disaster Assistance Registration

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| **Location** | **Current version** | Proposed Revision | Justification |
| **Language Needs/Preferences screen** (new screen immediately following **Personal Information** screen) | N/A | **Do you have a disability or language need that requires an accommodation to interact with FEMA staff and/or access FEMA programs?**  Yes No *(If Yes)***What do you need? (please select all that apply)*** Sign language interpreter
* CART (Communication Access Real-time Translation) (in person or remote)
* Text messages to communicate
* Assistive listening device
* Braille
* Large print
* Face-to-face assistance (reader or writer)
* Wheelchair access
* Language other than English
	+ Spanish
	+ Arabic
	+ Haitian Creole
	+ Russian
	+ Vietnamese
	+ Samoan
	+ Mandarin
	+ Other *(If selected, entry box will generate)*
* Other *(If selected, Enter Language Preference entry box generates)*
 | Accommodation question added to capture applicants with disabilities or people with limited English proficiency who may self-identify and need additional assistance accessing FEMA programs |
| **Language Needs/Preferences screen Help Text** | N/A | **ACCOMMODATION/ACCESS ASSISTANCE**Accommodation or assistance may include, but is not limited to, sign language interpreter, Braille, large print, accessible electronic format, or materials in a language other than English. FEMA programs may include, but are not limited to, your home inspection, town hall meetings, access to a Disaster Recovery Centers, or accessible temporary housing (if eligible).  | Help text added so applicant can better understand what is meant by “accommodation” and “FEMA Programs” if necessary. |
| **Other Needs screen** (new screen immediately following **Language Needs/Preferences** screen) | N/A | **Do you or anyone in your household have a disability that affects your ability to perform activities of daily living or requires an assistive device? (NOTE: An assistive device can include wheelchair, walker, cane, hearing aid, communication device, service animal, personal care attendant, oxygen, dialysis, etc.)** Yes No*(If Yes)* **Please select from the following the disability that affects your ability to perform activities of daily living (select all that apply):*** Mobility
* Cognitive/Developmental Disabilities/Mental Health
* Hearing or Speech
* Vision
* Self-Care
* Independent Living
* Other *(If selected, entry box generates)*
* Prefer Not to Answer

**Did you have any disability-related assistive devices or medically required equipment/supplies/support services damaged, destroyed, lost, or disrupted because of the disaster?**Yes No*(If YES)* **What was damaged, destroyed, lost, or disrupted because of the disaster? (select all that apply)*** Power or manual wheelchair
* Scooter
* Prosthesis
* Oxygen or respiratory equipment
* Medical equipment that depends on electricity
* Assistive technology device for hearing or vision, such as hearing aid, screen enlarging software, etc.
* Personal-care devices such as shower bench, bedside commode, Hoyer lift, or lift chair
* Environmental control or alerting devices
* Adaptive van or vehicle
* Walker, cane, or crutches
* Medication or medical supplies including adult diapers and catheters
* Service animal
* Personal assistance services/in-home care
* Dialysis
* Other *(If selected, generate entry box)*
 | Disability-related needs questions combined into one screen and relocated closer to the beginning of the RI script. Response options updated to provide clarity/more inclusive options. |
| **Disaster Related Losses Screen** | **Did you have any of the following losses?****Was your home damaged by the disaster?**Yes No Unknown**Was any of your personal property not including vehicles damaged by the disaster?**Yes No Unknown**Have you been without your essential utilities for 5 consecutive days or more?**Yes No**Were all of the vehicles in your household made undrivable due to the disaster?**Yes No**As a result of the disaster, do you have any new or additional child care costs OR has your household income been reduced, increasing your financial burden to pay for child care?**Yes No**Did you or anyone in your household use any type of mobility or assistive device such as a wheelchair, walker, cane, hearing aid, communication device, service animal, personal care attendant, or other similarly medically-related devices or services that assist with disabilities or activities of daily living?** Yes No | **Did you have any of the following losses?****Was your home damaged by the disaster?**Yes No Unknown**Was any of your personal property, not including vehicles, damaged by the disaster?**Yes No Unknown**Have you been without your essential utilities (electricity, gas, water) for 5 consecutive days or more?**Yes No**Were all of the vehicles in your household made undrivable due to the disaster?**Yes No**As a result of the disaster, do you have any new or additional child care costs OR has your household income been reduced, making it financially harder to pay for child care?**Yes No | Removed disability-related question from this screen to combine into one screen.  |
| **Special Needs General Categories Screen** | **You stated that you or a household member has a disability.  Please choose from the following:****Mobility**Yes No**Cognitive/Developmental Disabilities/Mental Health** Yes No**Hearing or Speech** Yes No**Vision**Yes No**Other**Yes No *(If Yes, generate entry box)* | Remove screen | Screen removed to combine disability-related needs questions into one screen |
| **Special Needs Specific Categories Screen** | **Based on the general categories of disability you have given, please select from the following list of specific categories related to those disabilities that have been affected by the disaster.****Mobility**WheelchairWalkerCaneLiftBath ChairPersonal Care Attendant**Cognitive/Developmental Disabilities/Mental Health**Personal Care AttendantOther (enter text)**Hearing or Speech**Hearing AidSign Language InterpreterTDD/TTYText messaging and/or other communication device**Vision**GlassesWhite CaneService AnimalBraille or other accessible communication deviceMagnifierOther**Other** *(If selected, generate entry box)* | Remove screen | Screen removed to combine disability-related needs questions into one screen |