**INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Date/Time:** _____ **Shelter Name/City/State:** _____ **DRO Name/#:** _____

**Family Last Name:** _____

**Primary language spoken in home:** _____ **Does the family need language assistance/interpreter?:** _____

**Names/ages/genders of all family members present:** _____

**If alone and under 18, location of next of kin/parent/guardian:** _____ **If unknown, notify shelter manager & interviewer initial here:** _____

**Home Address:** _____

**Client Contact Number:** _____ **Interviewer Name (print name):** _____

| INITIAL INTAKE | Circle | Actions to be taken | Include ONLY name of affected family member |
|---|---|---|---|
| 1. Do you need assistance hearing me? | YES / NO | If Yes, consult with Disaster Health Services (HS). | |
| 2. Will you need assistance with understanding or answering these questions? | YES / NO | If Yes, notify shelter manager and refer to HS. | |
| 3. Do you have a medical or health concern or need **right now**? | YES / NO | If Yes, stop interview and refer to HS immediately. **If life threatening, call 911.** | |
| **4. Observation for the Interviewer: Does the client appear to be overwhelmed, disoriented, agitated, or a threat to self or others?** | YES/ NO | **If life threatening, call 911.** If yes, or unsure, refer immediately to HS or Disaster Mental Health (DMH). | |
| 5. Do you need medicine, equipment or electricity to operate medical equipment or other items for daily living? | YES / NO | If Yes, refer to HS. | |
| 6. Do you normally need a caregiver, personal assistant, or service animal? | YES / NO | If Yes, ask next question. If No, skip next question. | |
| 7. Is your caregiver, personal assistant, or service animal inaccessible? | YES / NO | If Yes, circle which one and refer to HS. | |
| 8. Do you have any severe environmental, food, or medication allergies? | YES / NO | If Yes, refer to HS. | |
| **9. Question to Interviewer: Would this person benefit from a more detailed health or mental health assessment?** | YES / NO | If Yes, refer to HS or DMH. | ***If client is uncertain or unsure of answer to any question, refer to HS or DMH for more in-depth evaluation.** |
| STOP **STOP HERE!** STOP | | **REFER to:** HS Yes □ No □ DMH Yes □ No □ | Interviewer Initial ____ |

**DISASTER HEALTH SERVICES/DISASTER MENTAL HEALTH ASSESSMENT FOLLOW-UP**

| ASSISTANCE AND SUPPORT INFORMATION | Circle | Actions to be taken | Comments |
|---|---|---|---|
| Have you been hospitalized or under the care of a physician in the past month? | YES / NO | If Yes, list reason. | |
| Do you have a condition that requires any special medical equipment/supplies? (Epi-pen, diabetes supplies, respirator, oxygen, dialysis, ostomy supplies, etc.) | YES / NO | If Yes, list potential sources if available. | |
| Are you presently receiving any benefits (Medicare/Medicaid) or do you have other health insurance coverage? | YES / NO | If Yes, list type and benefit number(s) if available. | |
| **MEDICATIONS** | **Circle** | **Actions to be taken** | **Comments** |
| Do you take any medication(s) regularly? | YES / NO | If No, skip to the questions regarding hearing. | |
| When did you last take your medication? | | Date/Time. | |
| When are you due for your next dose? | | Date/Time. | |
| Do you have the medications with you? | YES / NO | If No, identify medications and process for replacement. | |

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| **HEARING** | **Circle** | **Actions to be taken** | **Comments** |
| Do you use a hearing aid and do you have it with you? | YES / NO | If Yes to either, ask the next two questions.<br>If No, skip next two questions. | |
| Is the hearing aid working? | YES / NO | If No, identify potential resources for replacement. | |
| Do you need a battery? | YES / NO | If Yes, identify potential resources for replacement. | |
| Do you need a sign language interpreter? | YES / NO | If Yes, identify potential resources in conjunction with shelter manager. | |
| How do you best communicate with others? | | Sign language? Lip read? Use a TTY? Other (explain). | |
| **VISION/SIGHT** | **Circle** | **Actions to be taken** | **Comments** |
| Do you wear prescription glasses and do you have them with you? | YES / NO | If Yes to either, ask next question.<br>If No, skip the next question. | |
| Do you have difficulty seeing, even with glasses? | YES / NO | If No, skip the remaining Vision/Sight questions and go to Activities of Daily Living section. | |
| Do you use a white cane? | YES / NO | If Yes, ask next question.<br>If No, skip the next question. | |
| Do you have your white cane with you? | YES / NO | If No, identify potential resources for replacement. | |
| Do you need assistance getting around, even with your white cane? | YES / NO | If Yes, collaborate with HS and shelter manager. | |
| **ACTIVITIES OF DAILY LIVING** | **Circle** | **Ask all questions in category.** | **Comments** |
| Do you need help getting dressed, bathing, eating, toileting? | YES / NO | If Yes, specify and explain. | |
| Do you have a family member, friend or caregiver with you to help with these activities? | YES / NO | If No, consult shelter manager to determine if general population shelter is appropriate. | |
| Do you need help moving around or getting in and out of bed? | YES / NO | If Yes, explain. | |
| Do you rely on a mobility device such as a cane, walker, wheelchair or transfer board? | YES / NO | If No, skip the next question. If Yes, list. | |
| Do you have the mobility device/equipment with you? | YES / NO | If No, identify potential resources for replacement. | |
| **NUTRITION** | **Circle** | **Actions to be taken** | **Comments** |
| Do you wear dentures and do you have them with you? | YES / NO | If needed, identify potential resources for replacement. | |
| Are you on any special diet? | YES / NO | If Yes, list special diet and notify feeding staff. | |
| Do you have any allergies to food? | YES / NO | If Yes, list allergies and notify feeding staff. | |
| **IMPORTANT! HS/DMH INTERVIEWER EVALUATION** | | | |
| **Question to Interviewer:** Has the person been able to express his/her needs and make choices? | YES / NO | If No or uncertain, consult with HS, DMH and shelter manager. | |
| **Question to Interviewer:** Can this shelter provide the assistance and support needed? | YES / NO | If No, collaborate with HS and shelter manager on alternative sheltering options. | |
| **NAME OF PERSON COLLECTING INFORMATION:** | HS/ DMH Signature: | | Date: |

**This following information is only relevant for interviews conducted at HHS medical facilities:** Federal agencies conducting or sponsoring collections of information by use of these tools, so long as these tools are used in the provision of treatment or clinical examination, are exempt from the Paperwork Reduction Act under 5 C.F.R. 1320.3(h)(5).

The authority for collecting this information is 42 USC 300hh-11(b) (4). Your disclosure of this information is voluntary. The principal purpose of this collection is to appropriately treat, or provide assistance to, you. The primary routine uses of the information provided include disclosure to agency contractors who are performing a service related to this collection, to medical facilities, non-agency healthcare workers, and to other federal agencies to facilitate treatment and assistance, and to the Justice Department in the event of litigation. Providing the information requested will assist us in properly triaging you or providing assistance to you.