



United States Department of

Health & Human Services

Office of the Assistant Secretary for Preparedness and Response (ASPR)



The ABCs of the Initial Intake and Assessment Tool

*The US Department of Health and Human Services
and
The American Red Cross*

August 10, 2009



Presenters

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U.S. Department of Health and Human Services



Agenda

- Opening Remarks and Introduction
- History of the Initial Intake and Assessment Tool
- Overview of the Initial Intake and Assessment Tool



Introduction

Office for **A**t-Risk Individuals, **B**ehavioral Health,
and Human Services **C**oordination (ABC)

Vision

All individuals and communities affected by public health emergencies and disasters shall have access to and receive the public health, behavioral health, and medical services they need, so that they can re-establish the activities of daily life.

Mission

Provide subject matter expertise, education, and coordination to internal and external partners to ensure that behavioral health issues and the needs of at-risk individuals are integrated in the emergency preparedness, response, and recovery activities of the nation.



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History of the Initial Intake and Assessment Tool



Why was the Tool Developed?

Developed post Hurricane Katrina to assist with the identification of individuals in shelters that:

- 1) May need accommodations provided to enable them to remain in a general population shelter
- 2) Ensure proper and safe placement of individuals with medical or functional needs beyond the scope and expertise of care offered in general population shelters



Initial Implementation of the Intake Tool

- Pilot testing:
 - WA/OR Flooding in Fall 2007 by Red Cross volunteers in shelters
 - Multiple shelter training exercises by Red Cross chapters including the National Level Exercise TopOff 4
- Initial feedback indicated the Tool met its intent but needed improvement to meet constraints of the disaster environment.
- Revisions occurred and the current version was released June 2008 with significant improvements to font size, length of time to complete, and order of questions.



Continued Implementation of the Intake Tool

- Hurricane season 2008 produced positive feedback regarding the Tool from Red Cross volunteers, shelter residents, and local public health departments who have shown particular interest in using the Tool.
- During Hurricanes Gustav and Ike, there were no formal grievances filed by shelter residents with the Office on Disability; this was widely attributed to the use of the Intake Tool.



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Memorandum of Understanding

Memorandum of Understanding
 Between
 The American National Red Cross
 and
 The U.S. Department of Health & Human Services



<p>Memorandum of Understanding between The American National Red Cross and The U.S. Department of Health and Human Services</p>	<p>Memorandum of Understanding between The American National Red Cross and The U.S. Department of Health and Human Services</p> <p>IV. Actions to which the Department of Health and Human Services and the Red Cross Commit to Ensure the Mutual Use of the Guidelines in the Red Cross - Health and Human Services Shelter Client Interview and Assessment Form</p> <p>The Department of Health and Human Services agrees to use the Assessment Tool and the guidelines included therein in all deployed Health and Human Services Federal Medical Shelters. Department of Health and Human Services teams will be trained in how to use the Assessment Tool and apply said guidelines to sheltering determinations. The Department of Health and Human Services agrees to monitor the Assessment Tool's usage to ensure compliance with the guidelines and facilitate feedback about how to improve the Assessment Tool.</p> <p>The Red Cross agrees to use the assessment tool in all shelters opened in response to incidents of National Significance and other disasters to which the organization responds. Red Cross employees and volunteers with responsibility for using the tool will be trained in its use in accordance with current Red Cross policies and implement it accordingly.</p> <p>V. Funding</p> <p>This memorandum of understanding is not an obligation nor a commitment of funds, but rather a statement of understanding between the parties.</p>	<p>VI. Points of Contact</p> <p>The review, request for changes and interpretation of this document coordinated by contract design</p> <p>For the Dept Services: Mr. Joseph F. Senior Program Officer of Preparedness US Department of Health and Human Services 200 Independence Avenue, SW Washington, DC 20420-4019 Joseph.Senior@hhs.gov</p> <p>For the Red Cross: Ms. Carol Hill Director, Health and Human Services Federal Response Preparedness American Red Cross 2025 E Street Washington, DC 20020-3038 hillcarol@redcross.org</p>	<p>Memorandum of Understanding between The American National Red Cross and The U.S. Department of Health and Human Services</p> <p>VII. Amendment, Termination, Entry into Force and Duration</p> <p>Both agencies agree to review the Initial Intake and Assessment Tool annually, or otherwise as required, to incorporate recommended changes agreed to by both parties. This memorandum of understanding remains valid regardless of mutually agreed upon changes to the Intake and Assessment Form.</p> <p>Except as otherwise provided, this memorandum of understanding may be amended by the mutual written consent of the authorized representatives for the Department of Health and Human Services and the Red Cross.</p> <p>Either party may unilaterally request renegotiation of this memorandum of understanding. Such renegotiations shall commence not later than 14 days after such request is made.</p> <p>Either party may terminate this memorandum upon thirty (30) days written notification to the other party. Such notice will be the subject of immediate consultation by the parties to decide upon the appropriate course of action.</p> <p>This memorandum of understanding will enter into effect upon signature of both parties and will remain in effect for a period of five years.</p>
<p>I. Purpose</p> <p>The purpose of this memorandum of understanding between the U.S. Department of Health and Human Services and the American Red Cross ("the parties") is to endorse the use of the Red Cross - Health and Human Services Initial Intake and Assessment Tool to facilitate triage for functional support at Red Cross shelters and Health and Human Services Federal Medical Shelters during an incident of National Significance or Public Health emergency response in which the Department of Health and Human Services and the Red Cross are engaged in supporting state, local or tribal authorities.</p>	<p>III. Authority</p> <p>Under section 2811 of the Antiterrorism and Effective Death Penalty Act, on behalf of the Secretary of Health and Human Services and the Department of Health and Human Services Federal Medical Shelters during an incident of National Significance or Public Health emergency response in which the Department of Health and Human Services and the Red Cross are engaged in supporting state, local or tribal authorities.</p> <p>The American Red Cross, as authorized by the U.S. Congress, act amended, 36 U.S.C. and carry on a system of international relief, apply the same in as provided by position, and other great need device and carry on the same."</p>	<p>VIII. Effect</p> <p>Nothing in this memorandum of understanding shall be construed to create or confer any rights, benefits, or obligations on any individual or entity, nor shall it be used to justify any action or inaction by any individual or entity.</p> <p>IX. No Precedent</p> <p>This document is not intended to create or confer any rights, benefits, or obligations on any individual or entity, nor shall it be used to justify any action or inaction by any individual or entity.</p>	<p>X. Approving Signatures</p> <p>The foregoing represents the understandings reached between the Department of Health and Human Services and the Red Cross upon the matters referred to therein.</p> <p>The following individuals are duly authorized to enter into this memorandum of understanding and to make decisions as contemplated hereunder on behalf of The American National Red Cross and the U.S. Department of Health and Human Services.</p>
<p>II. Background</p> <p>Under the National Response Plan, the Secretary of Health and Human Services, principally through the Assistant Secretary for Preparedness and Response, is responsible for coordinating all federal Public Health and Medical Services assistance to supplement state, local and tribal resources in response to public health and medical care needs for potential or actual incidents of National Significance. Executive Order (EO) 13447 calls for the federal government to appropriately support safety and security for individuals with disabilities in all types of emergency situations through a coordinated effort among federal agencies.</p> <p>The National Response Plan also identifies the Red Cross as having the Primary Agency role for the mass care section of Emergency Support Function (ESF) # 6 Mass Care.</p>	<p>IX. No Precedent</p> <p>This document is not intended to create or confer any rights, benefits, or obligations on any individual or entity, nor shall it be used to justify any action or inaction by any individual or entity.</p>	<p>X. Approving Signatures</p> <p>For the U.S. Department of Health and Human Services:</p> <p><i>W. Craig Vanderwagon</i> W. Craig Vanderwagon MD Assistant Secretary for Preparedness and Response (ASPR) Date: 5/25/07</p> <p>For the American Red Cross:</p> <p><i>Joseph C. Becker</i> Joseph C. Becker Senior Vice President Preparedness and Response Department Date: 5/24/07</p>	<p>X. Approving Signatures</p> <p>The foregoing represents the understandings reached between the Department of Health and Human Services and the Red Cross upon the matters referred to therein.</p> <p>The following individuals are duly authorized to enter into this memorandum of understanding and to make decisions as contemplated hereunder on behalf of The American National Red Cross and the U.S. Department of Health and Human Services.</p>
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<p>II. Background</p> <p>Under the National Response Plan, the Secretary of Health and Human Services, principally through the Assistant Secretary for Preparedness and Response, is responsible for coordinating all federal Public Health and Medical Services assistance to supplement state, local and tribal resources in response to public health and medical care needs for potential or actual incidents of National Significance. Executive Order (EO) 13447 calls for the federal government to appropriately support safety and security for individuals with disabilities in all types of emergency situations through a coordinated effort among federal agencies.</p> <p>The National Response Plan also identifies the Red Cross as having the Primary Agency role for the mass care section of Emergency Support Function (ESF) # 6 Mass Care.</p>	<p>IX. No Precedent</p> <p>This document is not intended to create or confer any rights, benefits, or obligations on any individual or entity, nor shall it be used to justify any action or inaction by any individual or entity.</p>	<p>X. Approving Signatures</p> <p>For the U.S. Department of Health and Human Services:</p> <p><i>W. Craig Vanderwagon</i> W. Craig Vanderwagon MD Assistant Secretary for Preparedness and Response (ASPR) Date: 5/25/07</p> <p>For the American Red Cross:</p> <p><i>Joseph C. Becker</i> Joseph C. Becker Senior Vice President Preparedness and Response Department Date: 5/24/07</p>	<p>X. Approving Signatures</p> <p>The foregoing represents the understandings reached between the Department of Health and Human Services and the Red Cross upon the matters referred to therein.</p> <p>The following individuals are duly authorized to enter into this memorandum of understanding and to make decisions as contemplated hereunder on behalf of The American National Red Cross and the U.S. Department of Health and Human Services.</p>
<p>I. Purpose</p> <p>The purpose of this memorandum of understanding between the U.S. Department of Health and Human Services and the American Red Cross ("the parties") is to endorse the use of the Red Cross - Health and Human Services Initial Intake and Assessment Tool to facilitate triage for functional support at Red Cross shelters and Health and Human Services Federal Medical Shelters during an incident of National Significance or Public Health emergency response in which the Department of Health and Human Services and the Red Cross are engaged in supporting state, local or tribal authorities.</p>	<p>III. Authority</p> <p>Under section 2811 of the Antiterrorism and Effective Death Penalty Act, on behalf of the Secretary of Health and Human Services and the Department of Health and Human Services Federal Medical Shelters during an incident of National Significance or Public Health emergency response in which the Department of Health and Human Services and the Red Cross are engaged in supporting state, local or tribal authorities.</p> <p>The American Red Cross, as authorized by the U.S. Congress, act amended, 36 U.S.C. and carry on a system of international relief, apply the same in as provided by position, and other great need device and carry on the same."</p>	<p>VIII. Effect</p> <p>Nothing in this memorandum of understanding shall be construed to create or confer any rights, benefits, or obligations on any individual or entity, nor shall it be used to justify any action or inaction by any individual or entity.</p> <p>IX. No Precedent</p> <p>This document is not intended to create or confer any rights, benefits, or obligations on any individual or entity, nor shall it be used to justify any action or inaction by any individual or entity.</p>	<p>X. Approving Signatures</p> <p>The foregoing represents the understandings reached between the Department of Health and Human Services and the Red Cross upon the matters referred to therein.</p> <p>The following individuals are duly authorized to enter into this memorandum of understanding and to make decisions as contemplated hereunder on behalf of The American National Red Cross and the U.S. Department of Health and Human Services.</p>



Memorandum of Understanding

Purpose

The purpose of this Memorandum of Understanding (MOU) between the U.S. Department of Health and Human Services (HHS) and the American Red Cross (ARC) is to endorse the use of the ARC—HHS Initial Intake and Assessment Tool to facilitate triage for functional support at ARC shelters and HHS Federal Medical Shelters (FMS) during an Incident of National Significance or Public Health emergency response in which HHS and the ARC are engaged in supporting State, Local or Tribal authorities.



Memorandum of Understanding

Actions to which HHS and ARC commit to ensure the mutual use of the guidelines in ARC—HHS shelter client interview and assessment form:

- HHS agrees to utilize the Assessment Tool and the guidelines included therein in all deployed HHS FMS facilities. HHS teams will be trained in how to use the Assessment Tool and apply said guidelines to sheltering determinations. HHS agrees to monitor the Assessment Tool's usage to ensure compliance with the guidelines and facilitate feedback on how to improve the Assessment Tool.
- The ARC agrees to utilize the Assessment Tool in all shelters opened in response to Incidents of National Significance and other disasters to which the organization responds. Red Cross staff, paid and volunteer, with responsibility for using the Tool will be trained in its use in accordance with current Red Cross policies and implement it accordingly.



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What is the Initial Intake and Assessment Tool?



Tool Design

First Section – Initial Intake

Second Section – Assessment

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: _____		Interviewer Name (print name): _____	
Client Contact Number: _____		Interviewer Name (print name): _____	
INITIAL INTAKE		Circle	Actions to be taken
NOTE: 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 HERE!		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
Have you been hospitalized or under the care of a physician in the past month?			
Do you have a condition that requires any special medical equipment/supplies? (E.g., oxygen, 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
Do you take any medication(s) regularly?			
When did you last take your medication?	YES / NO		If No, skip to the questions regarding hearing.
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.

INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
HEARING		Circle	Actions to be taken
Do you use a hearing aid and do you have it with you?			
Is the hearing aid working?	YES / NO		If Yes to either, ask the next two questions. If No, skip next two questions.
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
Do you wear prescription glasses and do you have them with you?			
Do you have difficulty seeing, even with glasses?	YES / NO		If No, skip the next question.
Do you use a white cane?	YES / NO		If Yes, ask next question. 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.
Do you need help getting dressed, bathing, eating, toileting?			
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
Do you wear dentures and do you have them with you?			
Are you on any special diet?	YES / NO		If needed, identify potential resources for replacement.
Do you have any allergies to food?	YES / NO		If Yes, list special diet and notify feeding staff.
IMPORTANT! HDHM INTERVIEWER EVALUATION			
Question to interviewer: Has the person been able to express shelter 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:
<small>This following information is only relevant for interviews conducted at RED medical facilities. Printed questions involving or generating collection of information by use of these tools, as long as these tools are used in the presence of a volunteer or staff or coordinator, are exempt from the Paperwork Reduction Act (PRA, 5 CFR 1320.3105). The primary purpose of this information is to determine the general progress of this collection is approximately that, in general, and to use the primary contact name of the information provided (include addresses in agency coordinates who are performing a service related to this collection, to medical facilities, emergency health care system, and to other federal agencies to facilitate treatment and assistance, and to the Federal Emergency Response System. Providing the information requested will assist us in properly helping you or providing assistance to you.</small>			



First Section – Initial Intake

(Questions 1-9)

1) Do you need assistance hearing me?

Circle YES / NO

If YES, consult with Disaster Health Services (HS).



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/ID: _____			
Family Last Name: _____			
Primary language spoken in home: _____			Does the family need language assistance/interpreter?: _____
Name(s)/age(s)/gender(s) 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 HERE		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			
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.	



First Section – Initial Intake (Questions 1-9)

2) Will you need assistance with understanding or answering these questions?

Circle YES / NO

If YES, notify shelter manager and refer to HS.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/R: _____			
Family Last Name: _____			
Primary language spoken in home: _____		Does the family need language assistance/interpreter?: _____	
Name(s)/age(s)/gender(s) 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			
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.	



First Section – Initial Intake

(Questions 1-9)

3) Do you have a medical or health concern or need **right now**?

Circle YES / NO

If YES, stop interview and refer to HS immediately. **If life threatening, call 911.**



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/R: _____			
Family Last Name: _____			
Primary language spoken in home: _____		Does the family need language assistance/interpreter?: _____	
Name(s)/age(s)/gender(s) 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		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.	



First Section – Initial Intake

(Questions 1-9)

- 4) **Observation for the Interviewer:** Does the client appear to be overwhelmed, disoriented, agitated, or a threat to self or others?
- Circle YES / NO
- If life threatening, call 911.**
- If YES, or unsure, refer immediately to HS or Disaster Mental Health (DMH).



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/ID: _____			
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		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			
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.	



First Section – Initial Intake

(Questions 1-9)

5) Do you need medicine, equipment, or electricity to operate medical equipment or other items for daily living?

Circle YES / NO

If YES, refer to HS.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/R: _____			
Family Last Name: _____			
Primary language spoken in home: _____		Does the family need language assistance/interpreter?: _____	
Name(s)/age(s)/gender(s) 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		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.	



First Section – Initial Intake (Questions 1-9)

6) Do you normally need a caregiver, personal assistant, or service animal?

Circle YES / NO

If YES, ask next question.

If NO, skip next question.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/R: _____			
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 HERE		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.	



First Section – Initial Intake (Questions 1-9)

7) Is your caregiver, personal assistant, or service animal inaccessible?

Circle YES / NO

If YES, circle which one and refer to HS.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/ID: _____			
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.	



First Section – Initial Intake

(Questions 1-9)

8) Do you have any severe environmental, food, or medication allergies?

Circle YES / NO

If YES, refer to HS.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/R: _____			
Family Last Name: _____			
Primary language spoken in home: _____		Does the family need language assistance/interpreter?: _____	
Name(s)/age(s)/gender(s) 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.	



First Section – Initial Intake (Questions 1-9)

9) **Question to Interviewer:**
 Would this person benefit from a more detailed health or mental health assessment?

Circle 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.**



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/ID: _____			
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 HERE!			
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.	



Functional Needs (C-MIST)

Communication – Individuals who have limitations that interfere with the receipt of and response to information.

Medical Care – Individuals who are not self-sufficient or do not have adequate support from caregivers and need assistance with managing medical conditions.

Maintaining Independence – Individuals requiring support to be independent in daily activities.

Supervision – Individuals who require the support of caregivers, family, or friends or limited ability to cope in a new environment.

Transportation – Individuals who cannot drive or who do not have a vehicle.



Second Section

Disaster Health Services / Disaster Mental Health Assessment Follow-Up

Have you been hospitalized or under the care of a physician in the past month? 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.) If YES, list potential sources if available.

Are you presently receiving any benefits (Medicare/Medicaid) or do you have other health insurance coverage? If YES, list type and benefit number(s) if available.

INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/ID: _____			
Family Last Name: _____			
Primary language spoken in home: _____		Does the family need language assistance/interpreter?: _____	
Name(s)/age(s)/gender(s) 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: _____		Interviewer Name (print name): _____	
Client Contact Number: _____		Circle Actions to be taken	
INITIAL INTAKE		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 811.	
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 811. 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 HERE		REFER to: HS Yes / No / DMH Yes / No / Interviewer Initial _____	
DISASTER HEALTH SERVICES/DISASTER MENTAL HEALTH ASSESSMENT FOLLOW-UP			
ASSISTANCE AND SUPPORT INFORMATION		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		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.





Second Section

Medications

Do you take any medication(s) regularly?
 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?
 If NO, identify medications and process for replacement.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Date/Time: _____ Shelter Name/City/State: _____ DRO Name/ID: _____			
Family Last Name: _____		Does the family need language assistance/interpreter?: _____	
Primary language spoken in home: _____			
Names/ages/genders of all family members present: _____			
If alone and under 18, location of next of kin/spouse/guardian: _____ If unknown, notify shelter manager & interviewer initial here: _____			
Home Address: _____		Interviewer Name (print name): _____	
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		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			
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.	



Second Section

Activities of Daily Living

Do you need help getting dressed, bathing, eating, toileting? If YES, specify and explain.

Do you have a family member, friend, or caregiver with you to help with these activities? 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? If YES, explain.

Do you rely on a mobility device such as a cane, walker, wheelchair, or transfer board? If NO, skip the next question. If YES, list.

Do you have the mobility device/equipment with you? If NO, identify potential sources for replacement.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
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. 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. 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. 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! HHS DMH INTERVIEWER EVALUATION			
Question to interviewer: Has the person been able to express shelter 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 interviewers involved in HHS medical facilities. Printed questions regarding or requesting collection of information by use of these tools, as long as these tools are used in the practice of medicine or other health care activities, are exempt from the Paperwork Reduction Act (PRA) (44 CFR 1.0133-305).



Second Section

Nutrition

Do you wear dentures and do you have them with you? If needed, identify potential resources for replacement.

Are you on any special diet? If YES, list special diet and notify feeding staff.

Do you have any allergies to food? If YES, list allergies and notify feeding staff.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
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. 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. 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. If No, skip the next question.	
Do you have your white cane with you?	YES / NO	If Yes, 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! HSDMH INTERVIEWER EVALUATION			
Question to interviewer: Has the person been able to express shelter 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 interviewers involved in HHS medical facilities. Printed agencies conducting or sponsoring collection of information by use of these tools, as long as these tools are used in the provision of treatment or care of conditions, are exempt from the Paperwork Reduction Act (PRA) 5 CFR 1320.3(a)(5). The validity for collecting this information is 01/10/2009 to 10/11/16. Your disclosure of this information is voluntary. The principal purpose of this collection is to approximately meet, in periodic addition to you. The primary burden of the information provided (include disclosure to agency contractors who are performing a service related to this collection, to medical facilities, emergency facilities, and to other federal agencies to facilitate treatment and assistance, and to the Federal Government to be used for its purposes. Providing the information requested will assist us in properly helping you or providing assistance to you.



Second Section

HS/DMH Interviewer Evaluation

Questions to Interviewer:

Has the person been able to express his/her needs and make choices? If NO or uncertain, consult with HS, DMH, and shelter manager.

Can this shelter provide the assistance and support needed? If NO, collaborate with HS and shelter manager on alternative sheltering options.



INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
HEARING			
Do you use a hearing aid and do you have it with you?	Circle YES / NO	Actions to be taken: If Yes to either, ask the next two questions. If No, skip next two questions.	Comments
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			
Do you wear prescription glasses and do you have them with you?	Circle YES / NO	Actions to be taken: If Yes to either, ask next question. If No, skip the next question.	Comments
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. 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			
Do you need help getting dressed, bathing, eating, toileting?	Circle YES / NO	Actions to be taken: Ask all questions in category. If Yes, specify and explain.	Comments
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			
Do you wear dentures and do you have them with you?	Circle YES / NO	Actions to be taken: If needed, identify potential resources for replacement.	Comments
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 IIRB medical facilities. Printed agencies conducting or sponsoring collection of information by use of these tools, as long as these tools are used in the provision of treatment or care or coordination, are exempt from the Paperwork Reduction Act (PRA) 5 CFR 1216.310(f).

The authority for collecting this information is 42 CFR 12856.1101 (c). Your disclosure of this information is voluntary. The principal purpose of this collection is to approximately assess, in periods addressed to you. The primary contact use of the information provided includes disclosure to agency contractors who are performing a service related to this collection, to medical facilities, emergency facilities, and to other federal agencies to facilitate treatment and assistance, and to the Federal Government to be aware of its status. Providing the information requested will assist us in properly helping you or providing assistance to you.



United States Department of

Health & Human Services

Office of the Assistant Secretary for Preparedness and Response (ASPR)



Ladies and Gentlemen,
Now It's Time for ROLE PLAY!