

DATE:	CLIENT/FAMILY NAME:	COUNTY/STATE:
Client location in shelter:		Interviewer:

This is a document to cover possible considerations for scenarios of access and functional needs. This is not an all-inclusive checklist, but rather serves as a simple guideline for referral purposes.

COMMUNICATION

NEED:	ACTION:
<input type="checkbox"/> Access to auxiliary communication service	<input type="checkbox"/> Provide written materials in alternative format (Braille, large and high contrast print, audio recording, or readers) <input type="checkbox"/> Provide visual public announcements <input type="checkbox"/> Provide qualified sign language or oral interpreter <input type="checkbox"/> Provide qualified foreign language interpreter
<input type="checkbox"/> Access to auxiliary communication device	<input type="checkbox"/> Provide access to teletypewriter [TTY, TDD, or CapTel] or cell phone with texting capabilities; pen and paper.
<input type="checkbox"/> Replacement of auxiliary communication equipment	<input type="checkbox"/> Provide replacement eyeglasses <input type="checkbox"/> Provide replacement hearing aid and/or batteries

MAINTAINING HEALTH

NEED:	ACTION:
<input type="checkbox"/> Special diet <input type="checkbox"/> Food Allergies _____ (type)	<input type="checkbox"/> Provide alternative (low sugar, low sodium, pureed, gluten-free, dairy-free, peanut-free) food and beverages; _____ (diet type)
<input type="checkbox"/> Medical supplies and/or equipment for every day care (including medications) <i>not</i> related to mobility <i>*For replacement eyeglasses or hearing aid, see Communication</i> <i>*For assistive mobility equipment (e.g., wheelchair), see Independence</i>	<p><i>Refer to Disaster Health Services to provide or procure one or more of the following:</i></p> <input type="checkbox"/> Replacement medication <input type="checkbox"/> Wound management/dressing supplies <input type="checkbox"/> Diabetes management supplies (e.g., test strips, lances, syringes) <input type="checkbox"/> Bowel or bladder management supplies (e.g., colostomy supplies, catheters) <input type="checkbox"/> Oxygen supplies and/or equipment
<input type="checkbox"/> Assistance with medical care normally provided in the home setting <input type="checkbox"/> Allergies (environmental or other high risk) _____ (type) <i>*For medical treatments that are not normally provided in the home setting (e.g., dialysis), see Transportation</i>	<p><i>Refer to Disaster Health Services to provide assistance with one or more of the following:</i></p> <input type="checkbox"/> Administration of medication <input type="checkbox"/> Storage of medication (e.g., refrigeration) <input type="checkbox"/> Wound management <input type="checkbox"/> Bowel or bladder management <input type="checkbox"/> Use of medical equipment <input type="checkbox"/> Universal precautions and infection prevention and control (e.g., disposal of bio-hazard materials, such as needles in sharps containers)
<input type="checkbox"/> Support for pregnant women <input type="checkbox"/> Support for nursing mothers; <input type="checkbox"/> Infant care availability	<input type="checkbox"/> Provide support by ongoing observation <input type="checkbox"/> Provide support and/or room for breastfeeding women <input type="checkbox"/> Assure diaper changing area is available
<input type="checkbox"/> Access to a quiet area	<input type="checkbox"/> Provide access to a quiet room or space within the shelter (e.g., for elderly persons, people with psychiatric disabilities, parents with very young children, children and adults with autism)
<input type="checkbox"/> Access to a temperature-controlled area	<input type="checkbox"/> Provide access to an air-conditioned and/or heated environment (e.g., for those who cannot regulate body temperature)
<input type="checkbox"/> Mental health care (e.g., anxiety and stress management)	<input type="checkbox"/> <i>Refer to Disaster Mental Health Services</i>

INDEPENDENCE	
NEED:	ACTION:
<input type="checkbox"/> Durable medical equipment for individuals with conditions that affect mobility	<input type="checkbox"/> Provide assistive mobility equipment (e.g., wheelchair, walker, cane, crutches) <input type="checkbox"/> Provide assistive equipment for bathing and/or toileting (e.g., raised toilet seat with grab bars, handled shower, bath bench) <input type="checkbox"/> Provide accessible cot (may be a crib, inclined head or other bed type)
<input type="checkbox"/> Power source to charge battery-powered assistive devices	<input type="checkbox"/> Provide power source to charge battery-powered assistive devices
<input type="checkbox"/> Bariatric accommodations	<input type="checkbox"/> Provide bariatric cot or bed
<input type="checkbox"/> Service animal accommodations	<input type="checkbox"/> Provide area where service animal can be housed, exercised, and toileted <input type="checkbox"/> Provide food and supplies for service animal
<input type="checkbox"/> Infant supplies and/or equipment	<input type="checkbox"/> Provide infant supplies (e.g., formula, baby food, diapers, crib)
SERVICES, SUPPORT AND SELF-DETERMINATION	
NEED:	ACTION:
<input type="checkbox"/> Adult personal assistance services <input type="checkbox"/> Child personal assistance services <i>*Incl. general observation and/or assistance with non-medical activities of daily living, such as grooming, eating, bathing, toileting, dressing and undressing, walking, etc.</i>	<input type="checkbox"/> Identify family member or friend caregiver <input type="checkbox"/> Assign qualified shelter volunteer to provide personal assistance services <input type="checkbox"/> Contact local agency to provide personal assistance services <input type="checkbox"/> Coordinate childcare support such as play areas; age-appropriate activities; equal access to resources.
TRANSPORTATION	
NEED:	ACTION:
<input type="checkbox"/> Transportation to designated facility for medical care or treatment <input type="checkbox"/> Transportation for non-medical appointment	<input type="checkbox"/> Coordinate provision of accessible shelter vehicle and driver for transportation <input type="checkbox"/> Contact local transit service to provide accessible transportation

Actions:

No needs identified

Contact Shelter Manager

Contact Disaster Mental Health Services

Agency, *please provide agency name*

Other _____

Followup/Resolution/date _____

Disaster Health Services print name/signature/date _____