

FEMA-ADMINISTERED INTAKE FORM

ADMINISTRATIVE INFORMATION		
Disaster Number:	Disaster Type:	Signed Consent Form - Date Received:
CASE MANAGER INFORMATION		
Full Name:	Work Phone:	Work Location:
TIER LEVEL		
Identify case manager, designated tier level, and date of tier level determination:		
Case Manager	Tier Level	Date of Determination
CLIENT CASE STATUS		
Case Status:		Date:
If Other, Explain:		
RETURN ON INVESTMENT		
Provide cost of goods or services provided to the client to address their disaster-caused unmet needs:		
Goods or Services	Cost	
RECORD NOTES		
Entry Date:	Purpose:	
Notes (information associated with the purpose):		

CLIENT INFORMATION

CLIENT INFORMATION

Applicant's Full Name (First, Middle, Last): Alias/Preferred Name: Age:

Gender: Preferred Language: Current Phone #: Current Alternate Phone #:

Current Email Address: FEMA Registration #: DCM Application Unique ID #:

CO-CLIENT INFORMATION

Relationship to Applicant: Reside with Applicant? Yes No

Co-Applicant's Full Name (First, Middle, Last): Alias/Preferred Name: Age:

Gender: Preferred Language: Current Phone #: Current Alternate Phone #:

Current Email Address:

HOUSEHOLD OCCUPANT INFORMATION

Household Size (including client and co-client): List the following for each occupant:

Table with 5 columns: Occupant's Full Name (First, MI, Last), Relationship to Applicant, Dependent (Y/N), Age, Gender. Includes checkboxes for Yes/No for dependent status.

CURRENT ADDRESS INFORMATION

Address:

Address Type:

Number of other individuals in current address household: Is location status long term? Yes No If no, enter Start Date: End Date:

Where will the clients go next if they can't stay?

DAMAGED DWELLING ADDRESS INFORMATION

Information on your primary residence damaged by the disaster:

Address:

Address Type:

Number of other individuals in pre-disaster household: Are you able to return? Yes No If yes, date of return:

SELF-ASSESSMENT

SELF-REPORTED DISABILITY/AT-RISK POPULATION

Self-Reported Special/At-Risk Populations, for example:

- Children Individuals with limited English proficiency Shelter/Homeless
- Elderly Individuals with disabilities in the household Other: _____

SELF-IDENTIFIED DISASTER-CAUSED UNMET NEEDS

Self-identified disaster-caused unmet need(s). Include those that apply. For example:

- Shelter
- Food and type (e.g. baby food)
- Treatment of an illness or physical injury (e.g. replacing prescriptions lost due to the disaster)
- Assistance locating a person or family missing due to the disaster
- Behavioral health access, crisis counseling, or spiritual and emotional care
- Financial assistance
- Legal assistance (obtaining services or fees)
- Essential clothing
- Essential furniture and/or appliances
- Transportation assistance (e.g. local travel, replacement vehicle, moving expenses)
- Employment
- Health insurance or healthcare access
- Functional needs assistance with services, devices, and modifications
- FEMA assistance (registration or appeals)
- Housing assistance (temporary, interim, to long-term)
- Housing repairs assistance (e.g. repair or rebuild of a dwelling)
- Utilities assistance (e.g. deposits or monthly expenses for water, electric, gas, heating oil, phone, etc.)
- Mold remediation assistance
- Assistance with accommodating or caring for a domesticated animal or pet
- Funeral cost assistance (e.g. memorial, transportation, disposition of remains)
- Assistance with temporary storage of household items
- Other disaster caused-unmet needs (list)

DISASTER-CAUSED UNMET NEEDS ASSESSMENT

BEHAVIORAL HEALTH ASSESSMENT

Referral Service:	Target Completion Date:
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Appointment Date/Time (if case manager is asked to make appointment for survivor)	Referral Result: <div style="text-align: right;">Result Date:</div>
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Assessment Date:	Is Disaster Survivor or anyone in the household in distress? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Would Disaster Survivor or anyone in the household like to speak to someone about coping with disaster-related stress? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined
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Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Referral Services, note all that apply. For example: <input type="checkbox"/> Behavioral health - other <input type="checkbox"/> Crisis counseling program <input type="checkbox"/> Community clinical provider <input type="checkbox"/> Disaster distress helpline <input type="checkbox"/> Counseling services <input type="checkbox"/> Private counsel directory
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Refer to Resource:	Comment:	Date:
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Names of those in need of services and a brief description of survivor self-reported symptoms/feelings of distress:

CHILDREN AND YOUTH ASSESSMENT

Assessment Date:	Are there children in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Is the disaster survivor caring for a foster child or foster children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined
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Prior to the disaster, was the disaster survivor's child in early education? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Prior to the disaster, was the disaster survivor's child in childcare? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	If yes, were the services disrupted as a result of the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Does the disaster survivor currently have a need for childcare? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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If childcare is needed but child is not attending, what are the barriers?

<input type="checkbox"/> Childcare provider closed due to the disaster	<input type="checkbox"/> Disaster survivor now unable to afford childcare due to unemployment losses
<input type="checkbox"/> Disaster survivor relocated to new area	<input type="checkbox"/> Disaster survivor unable to access site due to transportation
<input type="checkbox"/> Disaster survivor unable to find childcare for child with disability	<input type="checkbox"/> Disaster survivor unable to find childcare for infant
<input type="checkbox"/> Community barriers because of disaster	<input type="checkbox"/> Family care provider can no longer provide care post disaster
<input type="checkbox"/> Increased childcare costs	

Prior to the disaster, did disaster survivor get voucher assistance for childcare? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Are the disaster survivor's children currently attending school? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	If disaster survivor's children currently attending school, are they in the same school district post-disaster? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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Has your child missed any scheduled checkups or immunizations since the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Does disaster survivor have any concerns about how his/her child is managing feelings and behaviors post-disaster? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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If yes, please provide more information for referral:

Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Referral Services, note all that apply: <input type="checkbox"/> Case manager advocacy <input type="checkbox"/> Childcare <input type="checkbox"/> Child-other <input type="checkbox"/> Referral to social services <input type="checkbox"/> School district <input type="checkbox"/> Referral to early education <input type="checkbox"/> Referral to disaster distress helpline <input type="checkbox"/> Referral to childcare and referral agency <input type="checkbox"/> Referral to Voluntary Organization Active in Disasters (VOAD)/community group for school supplies
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Notes:

FEMA/SBA ASSESSMENT

Assessment Date:	Does disaster survivor have a FEMA Registration number? <input type="checkbox"/> Disaster survivor has not received <input type="checkbox"/> Does not know <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Disaster survivor received envelope but threw away
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Disaster survivor has submitted SBA application? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, SBA Application Submitted Date: _____	Disaster survivor has been approved for SBA loan? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, Date Approved: _____
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Disaster survivor has registered for FEMA Individual Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, Submitted Claim Date: _____	Disaster survivor has received non-compliance notice from FEMA Individual Assistance (IA)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined If yes, non-compliance notice received date: _____
Disaster survivor has received FEMA IA Benefit? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, IA benefit received date: _____	Disaster survivor has received MAX Grant from FEMA? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, MAX grant received date: _____
Disaster survivor has applied for FEMA Other Needs Assistance (ONA)? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, ONA application date: _____	Disaster survivor has received ONA? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, ONA received date: _____
Disaster survivor was denied for ONA? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined If yes, ONA denied date: _____	Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined

Referral Services, note all that apply:

<input type="checkbox"/> Assist with appeal for SBA denial	<input type="checkbox"/> Assist with completion of FEMA IA Application
<input type="checkbox"/> Assist with FEMA IA denial	<input type="checkbox"/> Assist with completion of SBA Loan Applications
<input type="checkbox"/> Assist with FEMA/SBA Sequence of Delivery	<input type="checkbox"/> Assist with FEMA ONA denial
<input type="checkbox"/> FEMA - Other	<input type="checkbox"/> Case manager assistance
<input type="checkbox"/> Provide education regarding FEMA/SBA Sequence of Delivery	<input type="checkbox"/> Obtain signed FEMA Disclosure release from Disaster Survivor
<input type="checkbox"/> Submit inquiry to FEMA IA Branch re: Disaster Survivor's ONA Application	<input type="checkbox"/> Submit inquiry to FEMA IA Branch re: Disaster Survivor's IA Application

Notes:

CLOTHING ASSESSMENT

Assessment Date: _____	Did any of the household members lose clothing as a result of the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	If yes, did disaster survivor submit a claim for the clothes with the insurance company (if has coverage)? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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Did disaster survivor/family have usable clothing and shoes for work or school? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Did disaster survivor/family have clothing appropriate for current weather conditions? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Referral Services, note all that apply: <input type="checkbox"/> Clothing - Other <input type="checkbox"/> Laundry Assistance <input type="checkbox"/> Voucher <input type="checkbox"/> Assistance with insurance claim/appeal <input type="checkbox"/> Clothing and other personal items <input type="checkbox"/> Referral to faith-based/community organization for clothing
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Notes (May include age, types and sizes of clothing/shoes needed):

EMPLOYMENT ASSESSMENT			
PRE-DISASTER EMPLOYMENT ASSESSMENT			
Assessment Date:	Employed Prior to Disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Looking for additional employment/increased hours? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	
POST-DISASTER EMPLOYMENT ASSESSMENT			
Did you lose your job because of the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined		Currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	
Looking for additional employment/increased hours? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Has disaster survivor applied for FEMA Disaster Unemployment Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	If yes, was Disaster Unemployment Assistance approved? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	If yes, was Disaster Unemployment Assistance denied? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Referral Services, note all that apply: <input type="checkbox"/> Education <input type="checkbox"/> Employment - other <input type="checkbox"/> Employment placement service <input type="checkbox"/> Job searching resources		
Notes (include information necessary to address the need): 			
FINANCIAL ASSESSMENT			
PRE-DISASTER FINANCIAL ASSESSMENT			
Assessment Date:	Annual Household Income:		
Monthly Income:	Monthly Expenses:		
Pre-Disaster, was disaster survivor or any household member receiving any of the following? Note as many as apply: <input type="checkbox"/> Unemployment insurance <input type="checkbox"/> Veterans disability payment <input type="checkbox"/> Supplemental security income (SSI) <input type="checkbox"/> Social security disability income (SSDI)			
POST-DISASTER FINANCIAL ASSESSMENT			
Estimated Annual Household Income:	Post-Disaster, was disaster survivor or any household member receiving any of the following? Note as many as apply: <input type="checkbox"/> Unemployment insurance <input type="checkbox"/> Veterans disability payment <input type="checkbox"/> Supplemental security income (SSI) <input type="checkbox"/> Social security disability income (SSDI)		
Disaster Unemployment Assistance received? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	If yes, amount:	If yes, duration: Start Date: _____ End Date: _____	
Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Referral Services, note all that apply: <input type="checkbox"/> Disaster Unemployment Assistance <input type="checkbox"/> Grant Assistance <input type="checkbox"/> Financial - other		
Notes (include information necessary to address the need): 			
FOOD ASSESSMENT			
Assessment Date:	Does Disaster Survivor have enough food to feed all members of the household? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Pre-Disaster, was disaster survivor or any household member receiving food assistance? Note as many as apply: <input type="checkbox"/> Assistance from local pantries/food banks <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Meals on wheels <input type="checkbox"/> Woman, Infant, and Children (WIC) benefits <input type="checkbox"/> Other	

Since the disaster, has the disaster survivor requested help with food from any entity/program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined
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Referral Services, note all that apply:

<input type="checkbox"/> Assistance with D-SNAP application	<input type="checkbox"/> Food - other
<input type="checkbox"/> Food bank/pantry	<input type="checkbox"/> Food delivery services
<input type="checkbox"/> Referral to community organizations for food needs	<input type="checkbox"/> Referral to mass care assistance for immediate food needs
<input type="checkbox"/> Referral to senior meals on wheels services	<input type="checkbox"/> Social services for WIC/SNAP/D-SNAP

Notes (include any necessary information needed to meet the need):

FURNITURE AND APPLIANCES ASSESSMENT

Assessment Date:	Did disaster survivor have furniture or home appliances destroyed in the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	If yes, did disaster survivor submit a claim for the furniture and appliance with their insurance (if any)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined
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If yes, did disaster survivor get replacement items from any nonprofit organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	If yes, was disaster survivor able to place/install replacement furniture and appliances in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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Referral Services, note all that apply:

<input type="checkbox"/> Appliances	<input type="checkbox"/> Assistance with insurance claim/appeal
<input type="checkbox"/> Assistance with install of new or removal of old appliances	<input type="checkbox"/> Referral to faith-based/community organization for replacement
<input type="checkbox"/> Furniture and Appliances - Other	<input type="checkbox"/> Assistance with FEMA

Notes (include any necessary information needed to meet the need):

HEALTH INSURANCE AND ACCESS TO HEALTH CARE ASSESSMENT

Assessment Date:	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined
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If yes, insurance type?

<input type="checkbox"/> Affordable Care Act (ACA)	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other Public	<input type="checkbox"/> State Children's Health Insurance Program (S-CHIP)
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Military Insurance	<input type="checkbox"/> Private	

Was this insurance lost as a result of the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined
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Referral Services, note all that apply:

<input type="checkbox"/> Call 911	<input type="checkbox"/> Clinic referral
<input type="checkbox"/> Durable medical equipment (e.g. wheelchair, cane)	<input type="checkbox"/> Emergency medical, health insurance related
<input type="checkbox"/> Health - other	<input type="checkbox"/> Medical care
<input type="checkbox"/> Medical equipment	<input type="checkbox"/> Medication

Notes (for example, may include name, types, services, or items needed):

HOUSING ASSESSMENT

Assessment Date:	In the disaster, was disaster survivor home damaged or affected? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Is the disaster survivor able to access the home? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Does disaster survivor consider home livable or inhabitable? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Disaster survivor damage rating: <input type="checkbox"/> Affected <input type="checkbox"/> Destroyed <input type="checkbox"/> Inaccessible <input type="checkbox"/> Major <input type="checkbox"/> Minor <input type="checkbox"/> No damage <input type="checkbox"/> Other <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Was disaster survivor relocated/evacuated? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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If yes, what are disaster survivor's plans to return home (if possible)?

Do all of disaster survivor's utilities work? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	If no, which utilities are not working? Note all that apply: <input type="checkbox"/> Electrical power <input type="checkbox"/> Sewer and sanitation <input type="checkbox"/> Phone <input type="checkbox"/> Gas <input type="checkbox"/> Water <input type="checkbox"/> Internet access <input type="checkbox"/> Fuel oil <input type="checkbox"/> Heat <input type="checkbox"/> Propane
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Details of disaster impacts to home:

Pre-disaster housing insurance status:

<input type="checkbox"/> Disaster survivor does not know insurance status	<input type="checkbox"/> Disaster survivor rented home and had renter's insurance
<input type="checkbox"/> Disaster survivor owned home and had homeowner's insurance	<input type="checkbox"/> Disaster survivor was uninsured
<input type="checkbox"/> Disaster survivor was insured but does not have insurance policy information	<input type="checkbox"/> Survivor was a renter <input type="checkbox"/> Survivor was a homeowner
<input type="checkbox"/> Disaster survivor had hazard-specific insurance for disaster type (flood, fire, earthquake)	<input type="checkbox"/> Other

Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	Referral services, note all that apply: <input type="checkbox"/> Assistance Housing Reservation <input type="checkbox"/> Debris removal, housing repairs <input type="checkbox"/> Shelter <input type="checkbox"/> Emergency housing mass care shelter <input type="checkbox"/> FEMA-Transitional Shelter Assistance (TSA) <input type="checkbox"/> Housing – other <input type="checkbox"/> FEMA – Other shelter <input type="checkbox"/> Other emergency housing <input type="checkbox"/> FEMA – Direct Housing <input type="checkbox"/> Tarp/blue roof <input type="checkbox"/> Muck and gut, well repair <input type="checkbox"/> Utility <input type="checkbox"/> Storage <input type="checkbox"/> Housing <input type="checkbox"/> Temporary housing, basic needs water, power heat
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Notes (include any necessary information needed to meet the need):

TRANSPORTATION ASSESSMENT

Assessment Date:	What was the disaster survivor's primary mode of transportation prior to the disaster? <input type="checkbox"/> Vehicle/motorcycle <input type="checkbox"/> Carshare <input type="checkbox"/> Ride with friends/family <input type="checkbox"/> Paratransit <input type="checkbox"/> Public transit <input type="checkbox"/> Bike <input type="checkbox"/> Walk <input type="checkbox"/> Other	If privately owned vehicle/motorcycle, is this method of transportation still working post-disaster? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined
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Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Referral services, note all that apply: <input type="checkbox"/> Transit pass <input type="checkbox"/> Transit tokens <input type="checkbox"/> Gas <input type="checkbox"/> Transportation <input type="checkbox"/> Transportation - other
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Notes (for example: unique transportation needs? Like for medical appts. Vs. employment? For med appts could be met with Medicaid, for example):

SENIOR SERVICES ASSESSMENT

Assessment Date:	At the time of the disaster was individual living in senior housing, assisted living, or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined	If yes, was the disaster survivor displaced following the disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Declined
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If yes, please explain the circumstances:

Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Referral services, note all that apply: <input type="checkbox"/> Assistance with accessing Veterans Affairs (VA) benefits <input type="checkbox"/> Home delivered meals (e.g. Meals on Wheels) <input type="checkbox"/> Referral to area agency on aging <input type="checkbox"/> Assistance with the Low Income Home Energy Assistance Program (LIHEAP) application <input type="checkbox"/> Referral to Adult Day Health Care Center <input type="checkbox"/> Referral to senior center
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Notes (information necessary to meet the need):

LEGAL SERVICES ASSESSMENT

Assessment Date:	Referral Needed? <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined <input type="checkbox"/> No <input type="checkbox"/> Declined	Referral services, note all that apply: <input type="checkbox"/> Other legal service <input type="checkbox"/> Referral to FEMA Disaster Legal Services program <input type="checkbox"/> Referral to Legal Aid
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Notes (information necessary to meet the need):

REFERRAL INFORMATION

BEHAVIORAL HEALTH REFERRAL

Referral Service:	Target Completion Date:	
Refer to Resource:	Appointment Date/Time (if case manager is asked to make appointment for survivor)	
Comment:	Date:	Referral Result:
		Result Date:

CHILD REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
FEMA/SBA REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
CLOTHING REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
EMPLOYMENT REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
FINANCIAL REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
FOOD REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:

FURNITURE AND APPLIANCES REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
HEALTH REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
HOUSING REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
TRANSPORTATION REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
SENIOR SERVICES REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:
LEGAL SERVICES REFERRAL		
Referral Service:		Target Completion Date:
Refer to Resource:		Appointment Date/Time (if case manager is asked to make appointment for survivor)
Comment:	Date:	Referral Result: Result Date:

RECOVERY PLAN

Include Applicable Disaster Survivor referrals and any other information relevant to the Recovery Plan.

Name:		Address:	
Email:			
Phone Numbers:		FEMA Registration #:	Case Management Manager:
DR - Disaster Declaration:		Disaster Survivor ID:	CM Phone #:
Disaster Survivor Plan Creation Date:	Case Manager Site Address:		
Summary of Recovery Plan priorities and next steps:			
FEMA-Administered DCM Case Manager Signature:			Date and Time:
Disaster Survivor Signature:			Date and Time:

DRAFT

PAPERWORK BURDEN DISCLOSURE NOTICE

Public reporting burden for this data collection is estimated to average 1 hour per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and submitting this form. You are not required to respond to this collection of information unless a valid OMB control number is displayed on this form. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing the burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC 20472-3100, Paperwork Reduction Project (1660-NW132)
NOTE: Do not send your completed form to this address.

PRIVACY NOTICE