

Attachment 7 ARC Intake Form

AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES INITIAL INTAKE AND ASSESSMENT TOOL			
Date/Time: _____		Shelter Name/Location: _____	
Name of Person: _____		DRO Name/Number: _____	
Names/Ages of all family members present: _____		Age: _____	
Age, gender, NOK/guardian: _____			
Home Address: _____			
NAME OF STAFF INITIATING ASSESSMENT: _____		Contact Number: _____	
INITIAL INTAKE	Circle	Actions to be taken	Comments (Include name of affected family member)
We will now be asking you a series of questions - Will you need assistance with understanding or answering these questions?	YES / NO	If Yes, determine needs in conjunction with shelter manager and Health Services.	
What language are you most comfortable with?		If other than English: refer to shelter manager if interpreter is needed. Once interpreter is available return to initial intake.	
Do you have a medical or health concern or need right now?	YES / NO	If Yes, stop interview and refer to Health Services immediately.	
How are you feeling? Physically? Emotionally?		If life threatening, call 911. Other urgent needs - refer to Health Services (HS) or Disaster Mental Health (DMH) now.	
Do you need any medicine, equipment or other items for daily living?	YES / NO	If Yes, refer to Health Services and ask next question.	
Do you need a caregiver or personal assistant?	YES / NO	If Yes, ask next question. If No, skip next question.	
Is your caregiver present and planning to remain with you?	YES / NO	If Yes, name of person. If No, refer to Health Services.	
Do you use a service animal?	YES / NO	If Yes, ask next two (2) questions. If No, skip next two (2) questions.	
Is the animal with you?	YES / NO	If No, ask next question.	
If No, do you know where the service animal is?	YES / NO	If No, notify local animal control of loss and attempt to identify potential resources for replacement.	
If under the age of 18, do you have a family member or responsible person with you?	YES / NO	If No, refer to Health Services or Disaster Mental Health. If Yes, locate parent or guardian to continue interview.	
This question is only relevant for interviews conducted at HHS medical facilities. Are you presently receiving any benefits (Medicare/Medicaid).	YES / NO	If Yes, list type and benefit number(s) if available.	
Do you have any severe environmental, food, or medication allergies?	YES / NO	If Yes, refer to Health Services.	
Question to Interviewer: Would this person benefit from a more detailed health or mental health assessment?	YES / NO	If Yes, Refer to Health Services or Disaster Mental Health.	*If client is uncertain or unsure of answer to any question, refer to HS or DMH for more in-depth evaluation.
REFERRED TO HEALTH SERVICES Yes <input type="checkbox"/> No <input type="checkbox"/>		REFERRED TO DISASTER MENTAL HEALTH Yes <input type="checkbox"/> No <input type="checkbox"/>	
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? (EpiPen, diabetes supplies, respirator, oxygen, dialysis, ostomy supplies, etc.)	YES / NO	If Yes, list and list potential sources 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.	
HEARING			
Do you need assistance in hearing me?	YES / NO	If Yes, ask next question. If No, skip the next question.	

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Would you like me to write the questions down?	YES / NO	If Yes, give client paper and pen. If no, go to the next category of questions.
Do you use a hearing aid?	YES / NO	If Yes, ask next two (2) questions. If No, skip next three questions.
Do you have your hearing aid with you?	YES / NO	If Yes, ask next two (2) 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		
Do you wear prescription glasses?	YES / NO	If Yes, ask next two (2) questions. If No, skip next two questions.
Do you have your glasses with you or with your personal belongings?	YES / NO	If No, identify potential resources for replacement.
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, determine if accommodation can be made in the shelter.
Do you need help moving around or getting in and out of bed?	YES / NO	If No, skip the remaining Vision/Sight questions and go to Activities of Daily Living section.
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, consult with HS and shelter manager to determine if accommodation can be made in the shelter.
ACTIVITIES OF DAILY LIVING		
Ask all questions in category.		
Do you need help getting dressed?	YES / NO	If Yes, explain.
Do you need assistance using the bathroom?	YES / NO	If Yes, explain.
Do you need help bathing?	YES / NO	If Yes, explain.
Do you need help eating? Cutting food?	YES / NO	If Yes, explain.
Do you have a family member, friend or caregiver with you to help with these activities?	YES / NO	If No, consult with HS and shelter manager to determine if general population shelter is appropriate.
NUTRITION		
Do you wear dentures?	YES / NO	If Yes, ask next question. If No, skip the next two questions.
Do you have them with you?	YES / NO	If No, 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.
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 DMH and shelter manager.
Question to Interviewer: Can this shelter provide the assistance and support needed?	YES / NO	If No, collaborate with shelter manager on alternative sheltering options.
NAME OF PERSON COLLECTING INFORMATION:	Signature:	Date:

This following information is only relevant for interviews conducted at HHS medical facilities: Federal agencies conducting or sponsoring collections of information by use of these tools are used in the provision of treatment or clinical examination, are exempt from the Paperwork Reduction Act under 5 C.F.R. 1320 3(h)(5).
 The authority for collecting this information is 42 U.S.C. 300hh-11(b) (4). Your disclosure of this information is voluntary. The principal purpose of this collection is to appropriately treat, or provide assistance to, you. The primary routine uses of the information provided include disclosure to agency contractors who are performing a service related to this collection, to medical facilities, non-agency healthcare workers, and to other federal agencies to facilitate treatment and assistance, and to the Justice Department in the event of litigation. Providing the information requested will assist us in properly treating you or providing assistance to you.