DEPARTMENT OF ELDER AFFAIRS
PLANNING TOOL FOR RAPID NEEDS EVALUATION

SECTION I

Part A: Client Information

1. Client's Name: _____ **2. Nickname:** _____
Last First Middle Initial

3. SSN# (last four digits only): _____ **4.** Date of Birth: _____ **5.** Shelter Arrival Date/Time: _____

6. If someone calls to inquire if you are in this shelter, do we have permission to tell them you are here? ☐Yes ☐No

7. Do we have permission to tell them where you have relocated once you leave the shelter? ☐Yes ☐No

8. Signature: _____ Date: _____ Time: _____

Part B: Insurance Information and ID Number

☐ Medicare: _____ ☐ Medicaid: _____

☐ Champus: _____ ☐ Private Insurance: _____

☐ TriCare for Life: _____ ☐ Other: _____

Part C: Pre-event Living Situation

1. ☐ Private Home ☐ Manufactured Housing ☐ Apartment/Condo
☐ HUD Housing ☐ Assisted Living Facility ☐ Independent Living Facility/Group Home ☐ Nursing Home
☐ Hotel ☐ Other_____

2. ☐ Own ☐ Rent

3. Live Alone ☐ Yes ☐ No If no, with whom do you live?:_____

4. Does client have access to a generator? ☐ Yes ☐ No Does client have access to generator fuel? ☐Yes ☐ No
Does client knows how to safely operate and refuel the generator? ☐ Yes ☐ No

Part D: Additional Information

1. If you can't return home when the shelter closes, do you have an alternative plan for housing? ☐ Yes ☐ No

2. If yes, where will you go? _____
Contact information for relocation site: Name: _____ Phone: _____
Street Address: _____ City: _____ State: _____

3. Do you have transportation? ☐ Yes ☐ No If yes, describe: _____

4. Do you receive services from an outside agency? ☐ Yes ☐No
If yes, Agency Name(s): _____
Contact**:** _____ _____ Phone: _____

5. Do you have a pet? ☐ Yes ☐ No Is the pet with you? ☐ Yes ☐ No Type of pet: _____
If you have a pet and it's not with you, where is it? _____

6. Do you have a service animal with you? ☐ Yes ☐ No If yes, type of animal: _____ Service: _____

Part E: Post-event Status of Housing Conditions

1. Do you have any information concerning the status of your residence? ☐ Yes ☐ No Date/Time: _____

2. Can you return to your residence? ☐ Yes ☐ No ☐ Unknown
If no, give reason: _____
☐ No Power ☐ Damage to Residence ☐ No Services ☐ No Caregiver ☐ Residence Flooded
☐ No Water ☐ Debris Blocking Residence ☐ Other: _____

Part F: Signature

The information above is true and correct to the best of my knowledge.

1. Client/Caregiver Signature: _____ ☐ Client ☐ Caregiver
Printed Name: _____ Date/Time: _____

2. Discharge Planner's Signature: _____ Date/Time: _____
Printed Name: _____ Contact Number: _____
Agency: _____

If the client has no post shelter plan or if the plan is not viable, refer the client to the shelter discharge planner.

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SECTION II

Part A: Client Information

1. Client's Name: _____ **2.** SSN (last four digits only): _____
3. Veteran □ Yes □ No **4.** Date of Birth: _____

Part B: Identify Housing Resources for Client

1. □ Family □ Friends □ Caregiver
2. □ Independent Living Facility □ Assisted Living Facility □ Nursing Home □ Other_____
3. □ Hotel **4.** Does the client need Red Cross assistance? □ Yes □ No
5. Are you willing to relocate temporarily to another county or state? □ Yes □ No

Part C: Services/Supplies

1. Is client in need of services? □ Yes □ No (Record services information below)

Services	Yes	No	Provider	Duration
Food/Meals				
Water				
Clothing				
Personal Care				
Toileting				
Transfer				
Walking/Mobility				
Transportation				
ESS/Food Stamps				
Medications				
Dialysis				

2. Medical Equipment Inventory (list supplier if applicable):

Equipment	Inventory	Need	Serial Number/Shelter Number	Supplier
Wheelchair				
Nebulizer/Oxygen				
Walker/Cane				

Part D: Relocation

1. Relocation contact information: Contact Name: _____ Phone: _____
Facility Name (if applicable): _____
Address: _____ City: _____ State: _____

2. Mode of Transportation to Relocation: _____ **Transported** by whom? _____

3. List any additional comments you think are relevant and/or are stated concerns of the client: _____
_____

4. Client/Caregiver Signature: _____ □ Client □ Caregiver
Printed Name _____ Date: _____

□ **Submit Reimbursement form to the Department of Health Authorized Personnel For Signature (if needed).**
5. Discharge Planner Signature: _____ Date/Time: _____
Printed Name _____Agency: _____

6. Discharge Date: _____ **7.** Action Taken/Recommendation: _____
_____

8. Follow Up Needed: _____
_____