

**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 know 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: \_\_\_\_\_  
 \_\_\_\_\_