

REGIONAL SHELTER COMMAND OPERATIONS CLIENT CASE MANAGEMENT REGISTRATION FORM

Date/Time:	Shelter Name/City/Town		
Applicant Name:	Spouse:		
Primary language spoken:	Need language assistance/interpreter?	Availability:	
Client Statement of the Disaster: (What happened? How were you impacted? How are you doing?)			
<input type="checkbox"/> What is the most important thing you lost?		<input type="checkbox"/> What is your most important need?	
Applicant current phone #	Alternate phone #		
Current Street Address/apt#	Mailing Address		
Email:	Number of Disaster-affected persons residing in current household:		
If under 18, location of next of kin/parent/guardian:	If unknown, notify shelter manager & interviewer initial here:		
Dependent: Name/Age:	Dependent: Name/Age:		
Pre-disaster home address:			
Insurance for this Disaster:			
<input type="checkbox"/> Structure	<input type="checkbox"/> Contents	<input type="checkbox"/> Flood/Earthquake	<input type="checkbox"/> Auto
<input type="checkbox"/> Umbrella	<input type="checkbox"/> Health	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Registered with FEMA:	FEMA#	Date:	
<input type="checkbox"/> Are you working with any other Agency? <input type="checkbox"/> Red Cross <input type="checkbox"/> Salvation Army <input type="checkbox"/> Interfaith <input type="checkbox"/> Specify:			
<input type="checkbox"/> Affiliations if wish to share (Faith, organizations, societies):			
Risk Inventory:			
<input type="checkbox"/> Shelter Resident <input type="checkbox"/> Dependent Children <input type="checkbox"/> Over 65 <input type="checkbox"/> Medical Condition <input type="checkbox"/> Disability (specify)			
<input type="checkbox"/> Active Military <input type="checkbox"/> Low Income <input type="checkbox"/> Single Parent <input type="checkbox"/> Uninsured/Underinsured <input type="checkbox"/> English Learner			
<input type="checkbox"/> Household Income if seeking Financial Assistance <input type="checkbox"/> Under \$10,000 <input type="checkbox"/> Under \$20,000 <input type="checkbox"/> Under \$40,000 <input type="checkbox"/> Under \$50,000			
<input type="checkbox"/> Client Permission to share information with other agencies: Signature			
Interviewer Name (print name):			Signature:
DO YOU HAVE A MEDICAL OR SAFETY CONCERN OR ISSUE RIGHT NOW? If yes, STOP and call for assistance NOW! Or Call 911			
Disaster Related Individual Unmet Needs Assessment			
	Immediate Unmet Needs (check applicable)	Actions Taken/Referrals	Follow Up
	Date		
	Water		
	Food		
	Clothing		
	Housing		
	Pets/Animals		
	Utilities		
	Transportation		
	Child care		
	Medical		

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Medications			
Mental Health			
Employment			
Pending eviction or utility shut-off			
Client Skills/Resources/Strengths			
Professional Skills:			
Lay Skills:			
Resources/Strengths:			
Brief Case History/Need			
Client's Plan for Recovery (Provide a copy of this Plan to the Client)			
Unmet Disaster Need	Action/Referral		Date
Client Case Resolution			
Date Case Transferred:	To:		
Date Case Closed:	By:		
Client Signature	Date		
BOH/Case Worker signature:			Date: