REGIONAL SHELTER COMMAND OPERATIONS

ACCESS AND FUNCTIONAL NEEDS INTAKE FORM

Date/Time:	Shelter Name/Community/State		
Family Last Name:			
Primary language spoken in home:	Intake Interviewer may need assistance with language/interpreter YES / NO		
Names/ages/genders of all family members present: Continue on over-side	2.	Age:	☐ male ☐ female
	3.	Age:	☐ male ☐ female
	4.	Age:	☐ male ☐ female
If alone and under 18, location of next of kin/parent/guardian:	If unknown, notify shelter manager & interviewer initial here:		
Home Address:			
Client Contact Number:	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.

COMMUNICATIONS	**Circle**	**Actions to be taken**	**Name of Individual/Comments**
Will you need assistance with understanding or answering these questions?	YES / NO	If Yes, notify shelter manager; refer to Additional Assistance.	
HEARING	**Circle**	**Actions to be taken**	**Name of Individual/Comments**
Do you use a hearing aid? If so, do you have it with you?	YES / NO	If Yes to either, ask the next two questions. If no skip next two.	
Is the hearing aid working?	YES / NO	If No, identify replacements.	
Do you need a battery?	YES / NO	If Yes, identify replacements.	
LANGUAGES	**Circle**	**Actions to be taken**	**Name of Individual/Comments**
How do you best communicate with others?	YES / NO	Languages? Sign language? Smartphone? Computer? Other?	
What languages can you communicate in?		Speak:	
		Read:	
		Write:	
Do you need a sign language interpreter?	YES / NO	If Yes, notify Interpreter Strike Team Leader	
VISION/SIGHT	**Circle**	**Actions to be taken**	**Comments**
Do you wear eyeglasses? Do you have them with you?	YES / NO	If no, ask if replacement is needed?	
Do you have difficulty seeing, even with glasses?	YES / NO	If No, skip to the next section	
Do you use a white cane?	YES / NO	If Yes, ask next questions	
Do you have your white cane with you?	YES / NO	If No, identify replacement.	
Do you need help getting around, even with your white cane?	YES / NO	If Yes, collaborate with Health Services and shelter manager.	
MEDICAL	**Circle**	**Actions to be taken**	**Comments**
Do you have any severe allergies? Environmental, chemical, food, medication?	YES / NO	If Yes, refer to Health Services/Food Services. List:	
Do you use special medical equipment or supplies? (Epi-pen, diabetes supplies, respirator, oxygen, dialysis, ostomy,	YES / NO	List:	
Do you have it with you?	YES / NO	If No, list potential sources	
Have you been in the hospital or under the care of a doctor in the past month?	YES / NO	If Yes, list reason.	
Do you take any medicine(s) regularly?	YES / NO		
When did you last take your medicine?		Date/Time.	

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When should you take your next dose?		Date/Time.	
Do you have the medicine with you?	YES / NO	If No, identify medications and process for replacement.	
Do you have your prescription with you?	YES / NO		
Do you have any other medical needs:	YES / NO	List:	
INDEPENDENCE for Daily Living	**Circle**	**Actions to be taken**	**Comments**
Do you use medicine, equipment or electricity to operate medical equipment or other items for daily living?	YES / NO	If Yes, refer to Heath Services.	
Do you normally use a caregiver, personal assistant, or service animal?	YES / NO	If Yes, ask next question. If No, skip next question.	
Is your caregiver, personal assistant, or service animal here or can they come? If NO, Circle which one	YES / NO	If No refer to Health Services/ DART. If yes, list their name.	
Do you need help getting dressed, bathing, eating, toileting	YES / NO	If Yes, specify and explain.	
Do you need help with your medications?	YES / NO	If Yes, specify and explain.	
Do you need help moving around or getting in/out of	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, determine if general population shelter is appropriate.	
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, identify potential resources for replacement.	
Do you wear dentures? Do you have them with you?	YES / NO	If needed, 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 food allergies?	YES / NO	If Yes, list food allergies and notify feeding staff.	
SUPERVISION AND SUPPORT	**CIRCLE**	**ACTIONS**	**Comments**
Do you or any of your family members require additional support or supervision?	YES / NO	If Yes, list type and frequency.	
Are you presently receiving any benefits e.g. Medicare, Medicaid) or do you have other health insurance?	YES / NO	If Yes, list type and benefit number(s) if available. Photocopy card.	
Do you need access to a 12-step program? Which one?	YES / NO	List program type.	
Would you like to register on the Red Cross SAFE and WELL website to let loved ones know you are OK?	YES / NO	If yes, provide registration form.	
Would you be able or willing to help others in the shelter?	YES / NO	How? Serve food, supervise children, organize service teams	
TRANSPORTATION	**Circle**	**Actions to be taken**	**Comments**
Do you need assistance with transportation?	YES / NO	If Yes, list destination and	
Do you have any other transportation needs?			
ADDITIONAL QUESTIONS TO INTERVIEWER			
Would this person benefit from a more detailed health or mental health assessment?	YES / NO	▪ If Yes, refer to Health Services or DMH. ▪ If client is uncertain or unsure of answer to any question, refer to HS or DMH for in-depth evaluation.	
Does the client appear to be overwhelmed, disoriented, agitated or a threat to self or others?	REFER to HS: DMH:	If life threatening, call 911. If yes, or unsure, refer immediately to Health Services	Interviewer Initial
Can this shelter provide the assistance and support needed?	YES / NO	If No, work with Health Services and shelter manager	
Has the person been able to express his/her needs and make choices?	YES / NO	If No or uncertain, consult with HS, DMH and shelter manager.	
HS/ DMH signature:			Date: