**Shelter Needs Assessment**

**VA Caribbean Healthcare System**

**Patient & Family Assistance Branch**

|  |  |
| --- | --- |
| Date: | Case Manager: |
| Location: | Official Shelter: Yes No: |

**Participants Contact Information**

|  |  |
| --- | --- |
| Name | DOB: Age: |
| Full SS: | Telephone contact: |
| Address: | |

**Significant others contact information**

|  |  |  |
| --- | --- | --- |
| Name: | Relation: | Contact info:  Phone: |
| Name: | Relation: | Contact info:  Phone: |
| Name: | Relation: | Contact info:  Phone: |

**Vulnerability profile**

|  |  |
| --- | --- |
| **Medical** | Unstable Chronic condition: Yes: No:  Explain (Dx, Sx & Challenges): |
| **Behavioral Health Needs** | Crisis intervention: Medication: Needs inpatient services:  Additional info: |
| **House damages** | Total loss: Minor damages: Undetermined:  Explain: |
| **Non-Food Items needs** | Clothing: Blankets: Mattresses: Cooking sets:  Other: |

|  |  |
| --- | --- |
| **Medications** | Name of Medication: Route:  Frequency: Doses: |
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| **Prosthetics** | Need of Equipment: Yes: No:  Explain: (Name of the Equipment/Urgency) |
| **Durable Medical Equipment**  **(DME)** | Need of DME: Yes: No:  Explain: (Name of the DME/Urgency) |

**Other organizations involvement**

|  |  |
| --- | --- |
| **The participants have received services by other Agencies?**  **Yes: No:** | **Red Cross: State Health Department**  **ASSMCA Police HHS Other** |
| **Explain:** | |

**Referrals and Outcomes**

|  |  |
| --- | --- |
| **Community / Private agencies** |  |
| **State Government agencies** |  |
| **Caribbean Healthcare System Programs** | **Homeless**  **Primary Care**  **Medical Services**  **Other services:**  **Explain Outcomes of Intervention:** |

**Document completed by: Date:**

**Program: Discipline:**