**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:**