CMIST Worksheet **Total number of family included on this form _____.**

DATE:	**CLIENT/FAMILY NAME:**	**COUNTY/STATE:**
Client location in shelter:		**Interviewer:**

This is a document to cover possible considerations for scenarios of access and functional needs. This is not an all-inclusive checklist, but rather serves as a simple guideline for referral purposes.

COMMUNICATION	
NEED:	**ACTION:**
☐ Access to auxiliary communication service	☐ Provide written materials in alternative format (Braille, large and high contrast print, audio recording, or readers) ☐ Provide visual public announcements ☐ Provide qualified sign language or oral interpreter ☐ Provide qualified foreign language interpreter
☐ Access to auxiliary communication device	☐ Provide access to teletypewriter [TTY, TDD, or CapTel] or cell phone with texting capabilities; pen and paper.
☐ Replacement of auxiliary communication equipment	☐ Provide replacement eyeglasses ☐ Provide replacement hearing aid and/or batteries
MAINTAINING HEALTH	
NEED:	**ACTION:**
☐ Special diet ☐ Food Allergies_____(type)	☐ Provide alternative (low sugar, low sodium, pureed, gluten-free, dairy-free, peanut-free) food and beverages; _____(diet type)
☐ Medical supplies and/or equipment for every day care (including medications) *not* related to mobility **For replacement eyeglasses or hearing aid, see Communication* **For assistive mobility equipment (e.g., wheelchair), see Independence*	***Refer to Disaster Health Services** to provide or procure one or more of the following:* ☐ Replacement medication ☐ Wound management/dressing supplies ☐ Diabetes management supplies (e.g., test strips, lances, syringes) ☐ Bowel or bladder management supplies (e.g., colostomy supplies, catheters) ☐ Oxygen supplies and/or equipment
☐ Assistance with medical care normally provided in the home setting ☐ Allergies (environmental or other high risk)_____(type) **For medical treatments that are **not** normally provided in the home setting (e.g., dialysis), see Transportation*	***Refer to Disaster Health Services** to provide assistance with one or more of the following:* ☐ Administration of medication ☐ Storage of medication (e.g., refrigeration) ☐ Wound management ☐ Bowel or bladder management ☐ Use of medical equipment ☐ Universal precautions and infection prevention and control (e.g., disposal of bio-hazard materials, such as needles in sharps containers)
☐ Support for pregnant women ☐ Support for nursing mothers; ☐ Infant care availability	☐ Provide support by ongoing observation ☐ Provide support and/or room for breastfeeding women ☐ Assure diaper changing area is available
☐ Access to a quiet area	☐ Provide access to a quiet room or space within the shelter (e.g., for elderly persons, people with psychiatric disabilities, parents with very young children, children and adults with autism)
☐ Access to a temperature-controlled area	☐ Provide access to an air-conditioned and/or heated environment (e.g., for those who cannot regulate body temperature)
☐ Mental health care (e.g., anxiety and stress management)	☐ ***Refer to Disaster Mental Health Services***

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INDEPENDENCE	
NEED:	**ACTION:**
☐ Durable medical equipment for individuals with conditions that affect mobility	☐ Provide assistive mobility equipment (e.g., wheelchair, walker, cane, crutches) ☐ Provide assistive equipment for bathing and/or toileting (e.g., raised toilet seat with grab bars, handled shower, bath bench) ☐ Provide accessible cot (may be a crib, inclined head or other bed type)
☐ Power source to charge battery-powered assistive devices	☐ Provide power source to charge battery-powered assistive devices
☐ Bariatric accommodations	☐ Provide bariatric cot or bed
☐ Service animal accommodations	☐ Provide area where service animal can be housed, exercised, and toileted ☐ Provide food and supplies for service animal
☐ Infant supplies and/or equipment	☐ Provide infant supplies (e.g., formula, baby food, diapers, crib)
SERVICES, SUPPORT AND SELF-DETERMINATION	
NEED:	**ACTION:**
☐ Adult personal assistance services ☐ Child personal assistance services **Incl. general observation and/or assistance with **non-medical** activities of daily living, such as grooming, eating, bathing, toileting, dressing and undressing, walking, etc.*	☐ Identify family member or friend caregiver ☐ Assign qualified shelter volunteer to provide personal assistance services ☐ Contact local agency to provide personal assistance services ☐ Coordinate childcare support such as play areas; age-appropriate activities; equal access to resources.
TRANSPORTATION	
NEED:	**ACTION:**
☐ Transportation to designated facility for medical care or treatment ☐ Transportation for non-medical appointment	☐ Coordinate provision of accessible shelter vehicle and driver for transportation ☐ Contact local transit service to provide accessible transportation

Actions:

☐ No needs identified
☐ Contact Shelter Manager
☐ Contact Disaster Mental Health Services
☐ Agency, *please provide agency name*

_____

☐Other_____

Followup/Resolution/date_____

_____

Disaster Health Services print name/signature/date_____