CMIST Worksheet

Total Number of Family Included on This Form: _____

Date:	Client/Family Name:	County/State:
Location in Shelter:		Interviewer:

This document covers possible considerations for access and functional needs. It is not all-inclusive, but serves as a 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 everyday 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 ❑ Allergies (environmental or other high risk) _____(type) **For medical treatments that are **not** normally provided in the home (e.g., dialysis), see Transportation*	***Refer to Disaster Health Services** to assist 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 / infection prevention and control (e.g., disposal of biohazard 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***

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 **Includes 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, and equal access to resources.
TRANSPORTATION	
NEED:	**ACTION:**
❑ Transportation to designated facility for medical care / treatment ❑ Transportation for non-medical appointment	❑ Coordinate provision of accessible shelter vehicle and driver for transportation. ❑ Contact local transit service to provide accessible transportation.

HOUSING CHALLENGES		
Pre-Disaster homeless	❑ Yes ❑ No	
Pre-Disaster precariously housed	❑ Yes ❑ No	
Pre-Disaster HUD housing occupant	❑ Yes ❑ No	Pre-Disaster Address:

Actions:

❑ No needs identified

❑ Contact Shelter Manager

❑ Contact Disaster Mental Health Services

❑ Agency, please provide agency name _____

❑ Other _____

_____

Disaster Health Services (name/signature/date)_____

This information may be shared with Shelter Manager, Recovery Services, and Disability Integration Services.