

Disaster Human Services Case Management Referral Form

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to enable ACF/OHSEPR to identify a disaster survivor's unmet needs and provide case management support that can connect a disaster survivor to services that meet their needs. Public reporting burden for this collection of information is estimated to average a total of 4 hours per respondent, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a voluntary collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is XXXX-XXXX and the expiration date is XX/XX/20XX. If you have any comments on this collection of information, please contact the Office of Human Services Emergency Preparedness and Response, 330 C St. SW, Washington, D.C. 20201.

Referral Type		
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Federal Disaster Assistance	<input type="checkbox"/> Legal Services
<input type="checkbox"/> Child Care	<input type="checkbox"/> Financial Assistance	<input type="checkbox"/> Medical
<input type="checkbox"/> Clothing	<input type="checkbox"/> Food Assistance	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Disability	<input type="checkbox"/> Health Insurance	<input type="checkbox"/> State human services
<input type="checkbox"/> Elder Care	<input type="checkbox"/> Housing - Short-term	<input type="checkbox"/> Veteran assistance
<input type="checkbox"/> Employment	<input type="checkbox"/> Housing - Long-term	<input type="checkbox"/> Other _____
Resource Provider (Name)		
Resource Provider Address (Street, City, State, Zip Code)		
Point of Contact, if applicable		
Office Phone	Cell Phone	Email Address
Current Business Hours	Appointment Date	Appointment Time
Directions to Resource Provider		
Notes		
Referral Result		
<input type="checkbox"/> Information Only		
<input type="checkbox"/> Eligibility for Resource Provider Pending		
<input type="checkbox"/> Eligible for Resource Provider		
<input type="checkbox"/> Ineligible for Resource Provider		
<input type="checkbox"/> Needs Met - Resource Provided		
<input type="checkbox"/> Needs Unmet		
<input type="checkbox"/> No Show		

Declined referral

Disaster Human Services Case Management Case Record Notes

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Entry Date:	
Purpose: <input type="checkbox"/> General Note <input type="checkbox"/> Close Record	
Entry Date:	
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Entry Date:	
Purpose: <input type="checkbox"/> General Note <input type="checkbox"/> Close Record	
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Entry Date:	
Purpose: <input type="checkbox"/> General Note <input type="checkbox"/> Close Record	
Case Closure	Reasons for Closure (select all that apply)
Date of Closure:	<input type="checkbox"/> Survivor completed their case management goals <input type="checkbox"/> Survivor identified outside resources and no longer needs assistance <input type="checkbox"/> Survivor was referred to another program that provides comparable case management services <input type="checkbox"/> Survivor chose to end participation in the program <input type="checkbox"/> Survivor cannot be reached at their provided <input type="checkbox"/> address, <input type="checkbox"/> phone, or <input type="checkbox"/> email

