

Cherry Lane Ward ER Family Assessment Form

ver:7/5/22

Please Print Clearly

Last Name _____	Street Address _____	Date _____
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PLEASE enter a # from the list below in this box
 1= Needs immediate assistance
 2= Needs assistance within 6 hours
 3= Needs assistance within 12 hours
 4= Needs assistance within 24 hours
 5= Needs no assistance



SHELTER _____	SANITATION _____
TRANSPORTATION _____	WASTE DISPOSAL _____
FOOD _____	MEDICAL SUPPLIES _____
WATER _____	OTHER _____
CLOTHING _____	_____
BLANKETS _____	_____

Phone/Text Number(s) _____

Family Status	
Head _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____
Spouse _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____
Child _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____
Child _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____
Child _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____
Child _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____
Child _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____
Child _____	Condition <input type="checkbox"/> Good <input type="checkbox"/> Needs: _____

Status of Housing Good Mild Damage Moderate Damage Severe Damage

Status of Transportation Working Not Working Have alternate transportation available

Status of Food Supply (days) None 1 3 7 14 30 More than 30

Status of Water Supply (days) None 1 3 7 14 30 More than 30

Needs Other Assistance (hours) Immediate 2 6 12 24 None

Willing to house others? Yes No How many? _____ How long? _____

Do you have adequate ways to stay warm? Yes No Use comment box for details if needed

Comments: (Please Print Clearly)

Assessment written by: _____