|  |
| --- |
| **Name of Disaster/Operation: Date:** |
| **1. Assessing Agency Information** |
| Organization doing the assessment (and collaborating organization): |
| Name of the Staff/Intake Person | Role in the community | Contact information |
| **2. Contact Information** |
| Providece/Region | Sub-City /Zone | Woreda/Kebele  |
| House Number # | Village Name  | Mailbox/Additional Description:  |
| Where are you currently residing?* Own Home
* Transitional Housing
* In Someone else’s Home
* Emergency Shelter
* Campsites
* Others
 | Phone(primary): |
| Alternative contact Person/Phone: |
| Email: |
| **3.Personal Information** |
| Caregiver's Name(Adult who is the parent/guardian) | Gender* Male
* Female
 | Date of Birth | Age | Primary Language |
| First Name: |
| Do you have an active Bank Account?* Yes
* No
 |
| Last Name: |
| **4. Household Information** |
| Did the child(ren)/ parent(s) served in military ? Yes /NoWhich Branch ? | Parent(s) death* Father
* Mother
* Both

Full Name : | Do you have a proof of death certificate? Y/NIssued by: |
| If Child(ren) death, how old are the parent(s)?* Over the age of 60 (60& 60+)
* Age 55 and disability with Disability
 | How many child(ren) do you have 18 and over ?How many child(ren) do you have under the age of 18?Do you care for a child with special needs (disability )? Y/N If yes , how many ? |
| Did the person who service in military :-* wounded
* ill (critical health condition)
* injured

Describe the injury : -  | Availability of medicines/medical supplies:🞏 Adequate🞏 Basic🞏 Inadequate | Does the person pay for medical treatment? * Yes
* No

Is treatment completed Y/N  |
| **5.List All Household Members( important to include child(ren) caring for)** |
| Full Name  | Gender* Male
* Female
 | Date of Birth | Age | Relationship to Caregiver |
| Full Name  | Gender* Male
* Female
 | Date of Birth | Age | Relationship to Caregiver |
| Full Name  | Gender* Male
* Female
 | Date of Birth | Age | Relationship to Caregiver |
| Full Name  | Gender* Male
* Female
 | Date of Birth | Age | Relationship to Caregiver |
| Full Name  | Gender* Male
* Female
 | Date of Birth | Age | Relationship to Caregiver |
| Full Name  | Gender* Male
* Female
 | Date of Birth | Age | Relationship to Caregiver |
| Full Name  | Gender* Male
* Female
 | Date of Birth | Age | Relationship to Caregiver |
| **6.** **Affirmation** |
|  I affirm that the information on this application is accurate. I affirm that the documentations provided is true and accurate. I acknowledge that approval is contingent upon the availability of resources. You are aware of this referral, and your information will be only shared with others to coordinate services, to make referrals to programs and benefits, and payment.  |
| Signature of Staff/Intake Person  |
| Caregiver (Caregiver Representative)Signature  |
| Name of Caregiver Representative Phone: |