American Red Cross

Shelter Dormitory Registration

___ *Date Entered into SCIA*

Family Name _____ SRT Triage Color *(completed by SRT): circle* (G Y R P)

Incident/DR#: _____ Shelter Name/Location:_____

***** This form is only used when the Shelter Client Information App is not accessible *****
https://redcross.org/scia
When the app is accessible, all client information must be entered and the paper record is destroyed.

Question to ask each client:

Is there anything urgent that you or your family need right now, or in the next 6-8 hours? This may include medications, diapers or baby formula, health/cultural/religious dietary meals, or other support for a health, mental health, disability, or other condition.

If the client has identified needs make an appropriate referral and record in the shelter log. **If a client discloses that they must register with a government agency, please notify the Shelter Manager or Shift Supervisor immediately.**

Does anyone in the household have environmental or other high-risk allergies? (circle): Yes No
If yes, ask "How would they normally remain safe in a new environment?" _____
Does anyone in the household have dietary needs for health, religious, or cultural reasons? (circle): Yes No
If yes, record details for each family member _____
Does anyone in the household have food allergies? (circle): Yes No
If yes, record details for each family member _____
Is anyone in the household accompanied by service animal(s)? (circle): Yes No

Primary Phone, Relay Service, and/or Email:	
Primary Language (circle)	English Spanish German Tagalog (Filipino) Chinese (Mandarin, Cantonese, Hokkien)
American Sign Language	Arabic Korean Russian Vietnamese French/French Creole Other:
If Not English, Is A Family Member Present Who Speaks English? (circle)**:**	Yes No

Name (Last, First)	Arrival Date	Room/Cot	Actual Departure Date

Number of Animals by Type: Dog ____ Cat ___ Small Animal ___ Reptile___ Bird ___ Other: ___ **Total Pets:** _____

Pet Location: ☐ Co-Located ☐ Off Site Partner Location ☐ Other:

Demographics County:_____ State: _____ Zip Code: _____

Gender Identity: (circle) Woman Man Non-binary/Gender-queer Two-Spirit Other_____ Prefer not to answer

Age breakdown of household (record # of each) __ 0-4 __ 5-19 __ 20-34 __ 35-49 __ 50-64 __ 65+ __ Prefer not to answer

Race: (Circle) Native American Asian African American Other Pacific Islander White Other Prefer not to answer

Hispanic or Latino: (circle) Yes No Prefer not to answer

Shelter Resident Transition Triage - *SRT Workers circle the applicable answer(s) and record points*

Question	Points	Total	Question	Points	Total
Pre-disaster housing situation?	Facility/Group Home – 0 Owned – 1 Renter – 3 Friend/Family, Motel, Couchsurfing, etc. – 4 Homeless – 24		Type of insurance(s)?	Homeowner's – 0 Renter's – 0 Hazard Specific – 0 Auto – 0 No insurance – 1	
Have you experienced homelessness in the last year?	N – 0 Y – 4		Functioning mobile phone?	Y – 0 N – 1	
Pre-disaster residence majorly damaged or destroyed?	Y – 3 N or Unknown – 0		Reliable transportation?	Y – 0 N – 2	
Pre-disaster residence accessible and safe to occupy?	Y or Unknown – 0 N – 1		A source of income?	Y – 0 N – 1	
A solution to transition from the shelter in the next 5 days?	Y – 0 N – 1		More than 4 individuals in the household?	Y – 1 N – 0	
Currently receiving financial assistance to support daily living? (ex. SNAP, SSI)	Y – 1 N – 0		Cognitive, physical, emotional, or spiritual needs that may impact recovery?	Y – 2 (Make a Referral) N – 0	
Green = 0 – 4	*Yellow = 5 – 12*	*Red = 13 – 22*	*Purple = 23+*	**Total pts**	
RC Care Case Number(s) (if applicable):					

CMIST - *To be Completed by DHS Workers*

Communication	Maintaining Health
☐ Access to auxiliary communication service ☐ Access to auxiliary communication device ☐ Replacement of auxiliary communication equipment ☐ Identify accompanying communication support person who will help with: (Describe support to be provided, i.e., interpretation, translation, and include language/communication need supported – ASL, Spanish, non-verbal communication, etc.)	☐ Medical supplies and/or equipment for everyday care (including medications) *not* related to mobility ☐ Assistance with daily living activities/medical normally provided in the home ☐ Support for pregnant women ☐ Support for nursing mothers ☐ Infant care availability ☐ Access to a quiet area ☐ Access to a temperature-controlled area ☐ Mental health care (e.g., anxiety and stress management)
Independence	**Services Support and Self Determination**
☐ Durable medical equipment for individuals with conditions that affect mobility ☐ Power source to charge battery-powered assistive devices ☐ Bariatric accommodations	☐ 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.*
Transportation	**Actions:**
☐ Transportation for medical care / treatment ☐ Transportation for non-medical appointment	☐ No needs identified ☐ Contact Shelter Manager ☐ Contact Disaster Mental Health Services ☐ Agency, *please provide agency name*
Actions Taken / Other Notes: (add additional sheet if necessary)	