



**5. HAVE YOU MADE A DECISION ABOUT WHERE YOU WILL LIVE PERMANENTLY?** YES NO

**Note:** Ask the client if s/he plans on staying in the area of if s/he is planning on relocating to another area. If the plan is to relocate, obtain at least the city and state they are relocating to. This information will be added to the database.

**5a. If YES, where?** I have not yet made a decision At my current address At my pre-disaster address (list): \_\_\_\_\_ At a new address, in my pre-disaster area: \_\_\_\_\_ Other: \_\_\_\_\_**5b. Regarding this housing, will you:** Own Rent/Lease Live with family/friends Reside in a transient shelter or is homeless Other: \_\_\_\_\_**5c. What type of housing will this be?** Apartment Hotel/Motel Mobile Home/Trailer Single family dwelling Other: \_\_\_\_\_**5d. Will this housing be subsidized by:** USDA FEMA HUD/Section 8 HUD/Grant or Loan HUD/Public Housing Other: \_\_\_\_\_ None**6. Ask the client the following: DO YOU FEEL THAT YOUR PRIMARY NEEDS, AS IDENTIFIED IN THE RECOVERY PLAN HAVE BEEN MET?** YES, completely YES, most of the needs have been met NO, the needs have only been partially met NO, needs have not been met**6a. If NO, why not? (check the one that best applies)** Agency lacks resources Needs are beyond the services and resources of the Agency Needs are beyond the services and resources of other agencies Unable to identify other service providers for remaining needs Other: \_\_\_\_\_**7. WERE YOU OR ANYONE IN YOUR HOUSEHOLD SEEKING A JOB (during the period that the case was opened)?** YES NO**7a. If YES, did you (or the person seeking the job) get a job?** YES NO

FILE #: \_\_\_\_\_

Referring back to the needs identified by the client at the time of completion of the Initial Assessment Form and the Disaster Recovery Partnership Plan, circle the "Identified Need" box if that need has been selected on the client's form. For each circled box, check the degree to which the need was met at time of case closure.

Code	Identified Need	Check the degree to which Need was met at time of Case Closure			
		Need Met	Need Partially Met	Need Not Met - Client Followed Up	Need Not Met - Client Did Not Follow Up
HWB	Health & Well-Being				
HO	Housing				
FO	Food / Nutrition				
US	Utilities / Services				
EMP	Employment / Job Training				
TR	Transportation				
Y	Children and Youth				
AD	Aged / Disabled				
APP	Application Assistance				
FI	Financial				
LEG	Legal				
BR	Benefits Restoration				
CL	Clothing				
FU	Furniture / Appliances				
LA	Language Assistance				
ED	Educational Services				
OT	Other				

FILE #: \_\_\_\_\_

Ask the client the following: To ensure that this agency continues to improve its services, we would like you to complete a short survey. Your name will not be used in any way and your responses will be kept anonymous. This survey will take about 10 minutes to complete. We would like you to complete it before leaving our office. If you would prefer, we can have another staff member help you complete it.

8. DO YOU AGREE TO COMPLETE THE SURVEY?     YES                       NO

If YES, proceed to the Client Satisfaction Survey. Have another staff member review it for completeness prior to client leaving the office.

Obtain signatures after Question 8 is completed

Signature of Client	Date
Printed Name of Case Manager:	Date
Signature of Case Manager	Date
Printed Name of Case Manager Supervisor:	Date
Signature of Case Manager Supervisor	Date