

**COUNTY USE ONLY**

**Date Received:** \_\_\_\_\_  
**Date Updated:** \_\_\_\_\_

## ORGANIZATION QUESTIONNAIRE

Please complete the questionnaire to provide information about your organization's availability to assist in providing services, staff, volunteers and/or items of need related to the Care & Shelter function for people needing assistance in disasters. There is no minimum requirement to assist.

Person Completing Assessment	Organization/Agency
Date	Time
Telephone Number	

### A. ORGANIZATION

Organization/Agency Name (If different from above)	Business Address
Mailing Address	City/Zip Code
Telephone Number	FAX Number
Website Address	

### B. ORGANIZATION CATEGORY

<b>Government Agency:</b> ( ) State    ( ) County    ( ) City    ( ) Other _____ <b>Community Non-Profit (CBO):</b> _____ <b>Faith Based/Other Non-Government (FBO/NGO):</b> _____ <b>Private Sector:</b> _____
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**Note:** All contact information is kept strictly confidential and is to be used for disaster related issues only.

### C. PRIMARY CONTACT PERSON

Name of Contact Person	Title/Position
E-mail Address	Personal Cell Phone

**D. 24-HOUR CONTACT PERSON (If different from Primary Contact)**

Name of Contact	Title/Position
E-mail Address	Personal Telephone (land line or cell)

**E. SECONDARY 24-HOUR CONTACT PERSON**

Name of Contact	Title/Position
E-mail Address	Personal Cell Phone

**F. SERVICES/SKILLS/SUPPLIES**

Please check each item of need that your organization will be able to assist with. If additional explanation is needed, explain in the comments area at the end of this form. If you check an “Other” box, please specify item of need to be provided.

**1. Health & Social Services Volunteers**

Please provide the number of volunteers per classification, if known.	
<input type="checkbox"/> Nurses _____	<input type="checkbox"/> Mental Health Specialists _____
<input type="checkbox"/> Doctors _____	<input type="checkbox"/> Adult Services Social Workers _____
<input type="checkbox"/> Emergency Medical Personnel (EMT) _____	<input type="checkbox"/> Children’s Services Social Workers _____
<input type="checkbox"/> First-Aid Certified Staff (CPR, etc.) _____	<input type="checkbox"/> Developmental Disability Specialists _____
<input type="checkbox"/> Alcohol & Drug Counselors _____	<input type="checkbox"/> Deaf/Hearing Specialists (ASL) _____
<input type="checkbox"/> Dentists _____	<input type="checkbox"/> Case Management Staff _____
<input type="checkbox"/> Parish Nurse Program _____	<input type="checkbox"/> Other: _____

**2. Health Supplies & Durable Medical Equipment**

<input type="checkbox"/> Pharmaceuticals	<input type="checkbox"/> Over the Counter Drugs
<input type="checkbox"/> First Aid Kits	<input type="checkbox"/> Wheel Chairs
<input type="checkbox"/> Canes	<input type="checkbox"/> Walkers
<input type="checkbox"/> Crutches	<input type="checkbox"/> PPE (Personal Protective Equipment)
<input type="checkbox"/> Other: _____	(e.g. Hearing Aids, glasses)

**3. Bilingual Translation Services**

<input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Laotian	<input type="checkbox"/> Hmong
<input type="checkbox"/> Filipino	<input type="checkbox"/> Sign Language/Braille	<input type="checkbox"/> Other:

**4. Food Services**

<input type="checkbox"/> Prepared Meals	<input type="checkbox"/> Snacks
<input type="checkbox"/> Food Commodities	<input type="checkbox"/> Bottled/Bulk Water
<input type="checkbox"/> Paper Plates	<input type="checkbox"/> Eating Utensils and Straws

**5. Transportation (Indicate whether for People and/or Supplies)**

<input type="checkbox"/> Car	<input type="checkbox"/> Van	<input type="checkbox"/> Bus	<input type="checkbox"/> Trucks
<input type="checkbox"/> Para transit	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Other:	
Number of vehicles to be provided: _____			
Will you provide drivers with the vehicles?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**6. Pet Sheltering and/or supplies and services**

<input type="checkbox"/> Shelter Site _____ (Location)	
<input type="checkbox"/> Pet Food _____ Quantity limits _____ (Specify: Cat, Dog, etc.)	
<input type="checkbox"/> Trained Staff	<input type="checkbox"/> Bedding
<input type="checkbox"/> Other: _____ (Medicine, Shampoo, Disinfectant, etc.)	

**7. Volunteers – Must be, at least, 18 years of age**

<b>Please provide the number of volunteers per activity, if known.</b>	
<input type="checkbox"/> Shelter Admitting/Tracking _____  <input type="checkbox"/> Food Service Assistance _____  <input type="checkbox"/> Transportation Drivers _____  <input type="checkbox"/> Clothing Giveaway _____  <input type="checkbox"/> Donation Acceptance/Tracking _____  <input type="checkbox"/> Shelter Cleaning/Sanitation _____  <input type="checkbox"/> Ham Operator(s): _____  <input type="checkbox"/> Whatever Assistance Needed _____  <input type="checkbox"/> Labor Team(s): _____	<input type="checkbox"/> Other Internal Shelter Assistance _____  <input type="checkbox"/> Personal Assistants _____ (To assist People with Disabilities and the Elderly)  <input type="checkbox"/> Donations Warehousing _____  <input type="checkbox"/> Child Care _____  <input type="checkbox"/> Supplies Intake & Distribution _____  <input type="checkbox"/> Clean-up Crew _____ ( To assist people in their homes)  <input type="checkbox"/> Pet Shelter Assistance _____  <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____
<p>Does your organization currently support an active volunteer organization?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p><b>If yes</b>, please provide the name of the organization and type of service provided by the organization: _____</p> <p>_____</p>	

**8. Shelter Training**

Individuals who work in disaster shelters must to be trained in American Red Cross and/or local Shelter Operations procedures. A background check is a standard requirement during the volunteer application process and is completed prior to scheduling training.

a. Would volunteers from your organization/agency be willing to attend American Red Cross disaster shelter training?

YES                       NO

b. Would your organization be willing to provide a list of the volunteers that are willing to participate in this training that includes names and contact information? *This information will only be used to schedule training for these individuals.*

YES                       NO

**9. Shelter Supplies (Please indicate quantities, if known)**

Sleeping	Personal Care	Other Needs
<input type="checkbox"/> Sleeping Mats _____	<input type="checkbox"/> Towels/Wash Cloths _____	<input type="checkbox"/> Flashlights _____
<input type="checkbox"/> Cots _____	<input type="checkbox"/> Toiletries _____	<input type="checkbox"/> Batteries – Size(s) _____
<input type="checkbox"/> Cribs/Cradles _____	<input type="checkbox"/> Feminine Products _____	<input type="checkbox"/> Duct Tape _____
<input type="checkbox"/> Pillows _____	<input type="checkbox"/> Baby Formula _____	<input type="checkbox"/> Trash Bags _____
<input type="checkbox"/> Sheets/Pillow Cases _____	<input type="checkbox"/> Diapers _____	<input type="checkbox"/> Candles _____
<input type="checkbox"/> ADA Compliant Cots _____ (Americans with Disabilities)	<input type="checkbox"/> Bar/Antibacterial Soap _____	<input type="checkbox"/> Cleaning/Sanitation Supplies _____
<input type="checkbox"/> Blankets _____	<input type="checkbox"/> Incontinence Supplies _____	<input type="checkbox"/> Portable Generator _____
<input type="checkbox"/> Sleeping Bags _____	<input type="checkbox"/> Detergent _____	<input type="checkbox"/> Hand Tools _____
<input type="checkbox"/> Other _____ (Specify)	<input type="checkbox"/> Portable Toilets _____ (ADA Compliant)	<input type="checkbox"/> Battery Powered Radio(s) _____
<input type="checkbox"/> Other _____ (Specify)	<input type="checkbox"/> Other _____ (Specify)	<input type="checkbox"/> Other _____ (Specify)

**G. IMMEDIATE RECOVERY SUPPLIES (available immediately to assist residents with minor repairs)**

The following items are for provision of supplies to residents to make simple repairs to homes that would allow families to remain sheltered in their own homes or return quickly to homes they had vacated.

<input type="checkbox"/> Corrugated Metal Sheets	<input type="checkbox"/> Lumber	<input type="checkbox"/> Nails, Brads, Screws
<input type="checkbox"/> Plastic Sheeting	<input type="checkbox"/> Tarps	<input type="checkbox"/> Mops, Brooms
<input type="checkbox"/> Portable Generators	<input type="checkbox"/> Tools _____ (Specify: Hammers, Screwdrivers, Saws, Etc.)	
<input type="checkbox"/> Other _____ (Specify)	<input type="checkbox"/> Other _____ (Specify)	

**H. LONG-TERM RECOVERY SERVICES**

<input type="checkbox"/> Replacement Housing	<input type="checkbox"/> Staff to locate Replacement Housing
<input type="checkbox"/> Employment Assistance	<input type="checkbox"/> Assistance Completing Applications
<input type="checkbox"/> Trauma Counseling Services	<input type="checkbox"/> Financial Assistance with Housing Deposits
<input type="checkbox"/> Other: _____ (Describe)	<input type="checkbox"/> Other: _____ (Describe)

**I. HOST SHELTER**

**Can your organization provide on-site Care & Shelter?**       YES       NO

Note: Just about any site could potentially be used to provide shelter during a disaster. But for the purpose of this portion of the questionnaire, we are looking for locations that are designed with features suitable to house people for several days. If your organization can provide this type of care and shelter, with the support of the American Red Cross and San Joaquin County Office of Emergency Services, please answer the following questions:

<b>Name &amp; Shelter Address:</b> _____	
<b>Please attach map/floor plan of facility if available.</b>	
<b>Shelter Capacity (Use 40 to 60 square feet per person to determine capacity)</b>	
<input type="checkbox"/> Small Shelter (Up to 25 persons)	Square footage, if known: _____
<input type="checkbox"/> Medium Shelter (26 – 99 persons)	Square footage, if known: _____
<input type="checkbox"/> Large Shelter (100 - ____ persons)	Square footage, if known: _____
<b>Facility Amenities</b>	
<input type="checkbox"/> Kitchen	<input type="checkbox"/> Laundry Facility <input type="checkbox"/> Adult Day Care
<input type="checkbox"/> Nursery	<input type="checkbox"/> Showers <input type="checkbox"/> Other _____ (Specify)
<b>Is your facility accessible for people with disabilities and the elderly?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited	
Note: If your organization has indicated that on-site Care & Shelter can be provided, follow-up surveys will be conducted by American Red Cross to insure the space meets specific Shelter Facility requirements.	

**J. HOST FACILITY**

**Can your organization provide a facility for meeting and/or training during a disaster?**

YES       NO

If yes, please answer the following questions:

**Name & Facility Address:** \_\_\_\_\_

**Meeting/Training Facility Capacity**       YES       NO

Small Facility

Medium Facility

Large Facility

**Outside Meeting/Training Area**       YES       NO

Small Area

Medium Area

Large Area \_\_\_\_\_

**Public Address System Available**       YES       NO

**Chairs/Tables Available**       YES       NO

Please use the below area for needed explanation or additional services you are available to provide.

**COMMENTS**

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