



Hospital Family Support Center Considerations

Family Support Center (FSC) refers to a designated location and coordinated set of services established by a hospital to support patients' loved ones, family members, and friends during a mass casualty incident, disaster, or other event resulting in increased demand for information, reunification, and support¹. FSC operations require the rapid mobilization of personnel, space, and resources to meet the needs of those seeking information about patients or impacted individuals. These events often occur without warning, and a concise, well-developed plan is necessary to ensure a structured, compassionate, and efficient response. The considerations in this document can assist hospitals in developing a new—or evaluating an existing—FSC plan.

Historically, hospitals have incorporated family support and reunification activities within broader “disaster” or “mass casualty incident (MCI)” plans. However, a wide range of incidents—both internal (e.g., fire, infrastructure failure, workplace violence) and external (e.g., severe weather, transportation accidents, mass violence)—may result in a surge of family members seeking information and assistance. While FSC operations are often closely aligned with MCI response, it is important that planning assumptions, terminology, and resource allocation specifically address **family support, reunification, and communication** which differ operationally from direct patient care activities.

The FSC plan may be developed as a **standalone annex** or integrated within the hospital's **Emergency Operations Plan (EOP)**. At a minimum, the EOP should define the incident command structure, identify FSC leadership roles and responsibilities, designate potential locations for FSC operations, outline staffing and resource requirements, and establish strategies for internal coordination, family communication, and public information management.

Hospitals should anticipate that during a **no-notice incident**, a significant number of family members, loved ones, and community members may arrive at the facility **prior to formal activation** of the FSC. As a result, the FSC plan should be activated anytime an MCI is declared. This convergence can create operational challenges related to access control, information management, and emotional distress. FSC planning should therefore be

¹ Family Support Centers are temporary and facility-based in contrast to Family Assistance Centers which are jurisdictional, are set up later in a response, and have a broader mission set. Transitioning families from FSC to FAC services is important to coordinate with jurisdictional emergency management.



multidisciplinary and include collaboration with internal departments (e.g., social work, chaplaincy, behavioral health, patient access, security, public affairs, case management) as well as external partners such as law enforcement, emergency management, healthcare coalitions, and community-based organizations.

While the written plan is essential, successful FSC operations depend heavily on **staff training, regular exercises, and resource availability**. Effective FSC activation can significantly reduce confusion, misinformation, and emotional distress, thereby improving overall incident management and patient-family experience.

This document provides **considerations and key planning questions** that hospital staff can use to guide FSC plan development and operations across functional domains. It also includes descriptions and examples of activities that support implementation of those considerations.

The scope of this document is primarily focused on the **initial operational period (first operational hours)** of an FSC activation, though some considerations extend into sustained operations.

For inquiries, questions, or suggestions for improvement, please contact the Enterprise Emergency Management team at EOC.CORP@HCAHealthcare.com

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1. Authorities and Activation

Considerations/Questions	Description/Examples
1.1 Who has authority to activate the FSC?	Activation authorities should reside with 24/7 in-house leadership, typically the Hospital Incident Commander, Administrator on Call, or House Supervisor. Backup authority should be clearly delegated (e.g., ED Charge Nurse) to ensure no delay in activation. An FSC is activated for most major mass casualty incidents, but considerations should be given about how to scale the FSC so it meets the needs for small and large events.
1.2 What triggers activation?	Activation should occur when there is a surge of patients or inquiries, when a mass fatality event occurs, when there is rapid convergence of families at the hospital, or when activation is requested by the Hospital Command Center or external agencies, while maintaining flexibility for non-MCI events such as high-profile incidents.
1.3 How is the FSC integrated into the Hospital Command Center?	The Family Support Center should be activated in parallel with the Hospital Command Center and operate within the established incident command structure, ensuring it receives direction, staffing, and validated information necessary to support operations.
1.4 What is the notification process?	The notification process should follow a standardized escalation pathway from the Emergency Department to the Administrator or House Supervisor, then to the Operator/PBX and mass notification system, with redundancy through radios, runners, or alternate communication systems. The FSC may be run by staff that are not 24/7 (e.g. social work, chaplaincy, child life, etc.) and may need to be initiated by someone other than the “lead”, though “leads” should still be towards the top of a call-in list.
1.5 What is the expected activation timeframe?	The Family Support Center should be operational within one hour during normal business hours and within two hours during after-hours incidents, supported by pre-identified staff and readily accessible equipment.
1.6 What criteria determine transition to Family Assistance Center?	Transition to a Family Assistance Center should occur when the incident exceeds hospital capability, when a community FAC is operational, or when long-term services are required, at which point the hospital transitions to a supporting role while maintaining coordination and information sharing.



2. Command and Control

Considerations/Questions	Description/Examples
2.1 Where does the FSC fall within the HCA Functional Area Incident Command structure?	The FSC function would be a combined effort across most HCA Functional Area command sections (Clinical, Support, Admin, Intel) and prioritized within each section to ensure clear reporting relationships and alignment with incident objectives. (e.g. Clinical = case management; Support = security, supply chain/FANS; Admin = HR, communication/PIO)
2.2 Who should be considered to lead the FSC?	A few considerations to lead the FSC would include a Social Work Director, Volunteer Services, Chaplaincy Lead, Case Management leader, or Emergency Management professional with experience in coordination and disaster response. Other entities, such as Child Life Services, can provide significant support.
2.3 Coordination with Hospital Command Center?	Coordination should be maintained through regular situation updates, typically every 30 to 60 minutes, supported by dedicated communication channels and assigned liaison roles between the FSC and HCC.
2.4 How is documentation tracked?	FSC leader should keep a log of times and activities (e.g. opening, briefings, notifications, closing) and a sign-in sheet should track involved staff for follow up.
2.5 Decision escalation?	Decisions should be escalated through the appropriate functional leader to the Incident Commander to ensure that FSC operations remain aligned with overall incident priorities and policies.



3. Location and Site Management

Considerations/Questions	Description/Examples
3.1 What is the primary and alternate FSC location?	<p>The FSC should have a pre-identified primary location such as a conference room or administrative space and a secondary alternate location such as an off-site facility, both of which must be physically separate from the Emergency Department, Operating rooms, and media areas. Scalability may be a consideration when choosing primary and secondary sites.</p> <ul style="list-style-type: none"> • Cafeterias often seem like a logical place for an FSC; however, staff often avoid visiting the cafeteria if it is being used for this purpose. • While the FSC should not be immediately proximal to the Emergency Department, consider spaces that don't require lengthy walks between EDs, ORs, and floor units, as families will require escorts to visit their family members - once identified - and long distances will require substantially more escorts, straining the labor pool.
3.2 Does the space support privacy and capacity?	<p>The space should include large waiting areas, private consultation rooms, quiet areas for grieving, and sufficient capacity to support a surge of families, potentially ranging from dozens to several hundred individuals.</p> <p>Consider a space that does <i>not</i> include TVs, as families will want to view current events, which could lead to greater emotion/intensity inside the room.</p>
3.3 What infrastructure is required?	<p>The FSC should include reliable Wi-Fi, telephones, sufficient electrical outlets and charging stations, and access to electronic health record systems to support operations. Call center capability should support the FSC.</p>
3.4 How is site flow managed?	<p>Site flow should be organized into clearly defined zones including entry screening, registration, waiting areas, private consultation rooms, and staff workspaces to ensure efficient movement and operations.</p>
3.5 How are accessibility needs addressed?	<p>Accessibility considerations should include ADA compliance, interpreter services, mobility assistance, and culturally appropriate services to meet the needs of diverse populations.</p>
3.6 Where are private meeting/notification rooms?	<p>Private rooms should be available for death notifications, sensitive discussions, and psychological support to ensure confidentiality and dignity. Optimally these rooms are proximate to the waiting area for ease of access.</p>



4. Security and Access Control

Considerations/Questions	Description/Examples
4.1 How is access controlled?	Access should be controlled through designated entry points staffed by security personnel, supported by credentialing processes and identity verification procedures.
4.2 What screening procedures are used?	Screening should verify identity, relationship to the patient, and intent for entry to ensure that only appropriate individuals are allowed access.
4.3 How is media restricted?	Media access should be restricted from the FSC, and all media inquiries should be directed to the Public Information Officer for coordination and response.
4.4 What law enforcement support is needed?	Law enforcement may be required for crowd control, maintaining security presence, and supporting investigative activities related to the incident. *Note: During a large-scale community MCI, your LEO may be pulled away from a post to respond. Consider a plan to ramp-up security staffing without the support of law enforcement.
4.5 How is crowd control managed?	Crowd control should be managed by limiting visitors, utilizing overflow areas, and implementing structured queue systems. Depending on the event, you could consider limiting the number of family members per patient. This needs to be done in consultation with facility leadership, as this could escalate tensions amongst the group.



5. Staffing

Considerations/Questions	Description/Examples
5.1 What should the staffing model look like?	The staffing model should be scalable and adaptable based on the size and complexity of the incident, and it should incorporate a combination of clinical personnel, patient access, and administrative staff to ensure that all operational and family support needs within the Family Support Center are effectively addressed.
5.2 What departments provide staffing?	Staffing should be provided by a multidisciplinary group of departments, including social work, chaplaincy, behavioral health, patient access, security, administrative support, and case management, to ensure comprehensive support for both operational functions and family needs.
5.3 What teams are required?	The Family Support Center should include dedicated teams such as intake staff, family liaison personnel, call center representatives, death notification teams, and behavioral health support staff to ensure that all aspects of FSC operations are adequately covered. *During a large-scale event, multiple functions will likely be covered by one individual/department leader.
5.4 How is staffing sourced?	Staffing should be sourced through internal labor pools, established call-back procedures for off-duty staff, and external partners when necessary to ensure that sufficient personnel are available to sustain operations throughout the incident. Due to the challenging nature of these assignments, staff should be made aware of the potential roles during the planning process.
5.5 How is staff stress managed?	Staff stress should be actively managed by implementing structured shift rotations, ensuring that staff are provided with regular breaks, and offering access to behavioral health resources to support their emotional well-being and maintain operational effectiveness during prolonged incidents. Post-incident support for FSC staff should include stress management, voluntary debriefs, and available individual professional consultation.



6. Intake, Registration, and Tracking

Considerations/Questions	Description/Examples
6.1 How are families registered and tracked?	Families should be registered using standardized forms and/or digital systems that capture key identifying information, and each family should be assigned a unique identifier to support tracking. Digital tools, including QR codes, may be used to facilitate multi-departmental access and coordination. It is essential that the paper or digital forms are developed during the planning process, NOT at the time of the activation of the FSC.
6.2 What information is collected?	Information collected should include the individual's name and contact information, the patient's name and date of birth, the relationship to the patient, and descriptive information if the patient is missing or unidentified. ²
6.3 What systems/forms are used?	Systems should include integration with the electronic health record, supported by paper backup forms and digital registration tools, and information should be cross-referenced with patient tracking systems to ensure accuracy and consistency. Facilities in states that use sophisticated patient tracking systems (e.g. Pulsara) should plan to integrate with these systems; however, it is unlikely that the reunification tools within these systems will be available at the start of the event. Therefore, it is critical to maintain paper or digital forms outside of these systems.
6.4 How are unidentified patients matched?	Unidentified patients should be matched using physical descriptors such as scars, tattoos, jewelry, fingernail art, and other identifying features, as well as clothing descriptions and photographs when appropriate, to assist with accurate identification.
6.5 How are discrepancies resolved?	Discrepancies should be resolved using established verification protocols, escalation to leadership when necessary, and thorough documentation of all updates to maintain accuracy and accountability.

² HIPAA and Disasters: What Emergency Professionals Need to Know - information can be collected that aids in the reunification of families and patients.

<https://files.asprtracie.hhs.gov/documents/aspr-tracie-hipaa-emergency-fact-sheet.pdf>

7. Patient Identification and Reunification

Considerations/Questions	Description/Examples
7.1 How are patients located?	Patients should be located using the EHR, EMS reports, and internal patient tracking systems to ensure accurate and timely identification. Coordination with FSC at other hospitals receiving patients may also be necessary.
7.2 What should coordination look like?	Coordination should include assigning a dedicated liaison to each family, when possible, and facilitating escorting of family members inside the facility to ensure continuity and support throughout the reunification process.
7.3 How is verification managed?	Verification should be conducted using photo identification and supporting documentation to confirm relationships before information is shared or reunification occurs.
7.4 How are unidentified patients identified?	Identification of unidentified patients should involve the use of physical descriptors including hair/eye color, approximate height/weight, scars, tattoos, jewelry, fingernail polish/art, clothing (when known), etc. Forms should be standardized when this information is needed. Information provided by family members should be coordinated with other hospitals, the medical examiner, and law enforcement as needed.
7.5 How are families informed?	Families should be informed through scheduled briefings, individualized one-on-one updates, and private communication methods to ensure clarity, accuracy, and sensitivity. Ideally, senior leaders (e.g. CEO, CMO) from the facility provide the updates to families.
7.6 How is reunification coordinated within the hospital?	Reunification should be coordinated by escorting families to patients when appropriate, ensuring that the patient is clinically stable and ready, and maintaining privacy and dignity throughout the process. Escorts will be needed that know the hospital campus well.
7.7 How is multi-hospital reunification handled?	Multi-hospital reunification should be coordinated through healthcare coalitions or other regional structures and may utilize regional patient tracking systems to ensure accurate information sharing and efficient reunification across facilities.



8. Unaccompanied Minors and Vulnerable Populations

Considerations/Questions	Description/Examples
8.1 How are unaccompanied minors identified?	<p>Unaccompanied minors should be identified immediately upon arrival or during intake, and social work or case management should be notified promptly to initiate appropriate protective measures.</p> <p>*Consider proactive relationships and liaison with local schools, who have student records that may include parent names, emergency contact numbers, possible physical identifiers/photos.</p>
8.2 Where is the safe area?	<p>A designated Pediatric Safe Area should be established with appropriate supervision to ensure the safety and well-being of unaccompanied minors.</p> <p>Factors to consider:</p> <ul style="list-style-type: none"> • Staffing and the qualifications of the staff could be subject to state regulations • Consider ratios of staff to children
8.3 What verification is required for release?	<p>Release of minors should require verification of legal guardianship through documentation, photographs, or other validating information, and may involve coordination with local child services agencies when necessary.</p>
8.4 What agencies support reunification?	<p>Agencies that support reunification include child protective services, law enforcement, and non-governmental organizations that specialize in family assistance and child welfare.</p>
8.5 How are access/functional needs addressed for children?	<p>Access and functional needs should be addressed by providing interpreter services, mobility assistance, and medical support to ensure equitable access to services for all individuals. Age-appropriate supervision and support should be available.</p>
8.6 What safeguards prevent errors?	<p>Safeguards should include multi-step verification processes, thorough documentation, and supervisory review to prevent errors and ensure safe and appropriate reunification.</p>



9. Logistics and Resources

Considerations/Questions	Description/Examples
9.1 What supplies are required?	Required supplies should include forms, technology equipment, comfort items, and signage to support both operational and family needs within the FSC. *Please see appendix section for a comprehensive list of supplies/comfort items to include.
9.2 Where are start kits located?	Start kits should be pre-staged and pre-positioned in accessible locations, with inventory lists maintained to ensure readiness for rapid deployment.
9.3 How are food and water provided?	Food and water should be provided through coordination with dietary services/FANS to ensure that families and staff have access to necessary sustenance during operations. HCA does not accept food donations from individuals within the community, despite being well-intentioned.
9.4 How are interpreter services provided?	Interpreter services should be available through both in-person and virtual options to support communication with individuals who have limited English proficiency or other communication needs.
9.5 How is IT supported?	Information technology support should be provided by dedicated IT personnel to ensure access to electronic health records, communication systems, and other critical tools.
9.6 How is signage managed?	Signage should be pre-printed and readily deployable to support wayfinding, operational flow, and communication within the FSC. *Please see appendix section for examples/templates.



10. Behavioral Health and Support Services

Considerations/Questions	Description/Examples
10.1 What behavioral health resources exist?	Behavioral health resources should include on-site professionals who are available to provide psychological support and emotional stabilization for families and staff. HCA has internal and external resources that can be deployed to support the onsite teams, when needed.
10.2 How is psychological first aid delivered?	Psychological first aid should be delivered by trained staff who provide immediate emotional support and stabilization in a compassionate and structured manner.
10.3 What is the role of chaplaincy?	Chaplaincy services should provide spiritual care, grief support, and assistance to meet the emotional and spiritual needs of families.
10.4 What private spaces are available?	Private spaces should be designated as quiet rooms where individuals can receive emotional support and process grief in a safe and controlled environment.
10.5 What additional services are provided?	Additional services should include providing food and water, blankets, communication tools such as phones and chargers, and comfort items such as toys to support families during their time in the FSC.



11. Communications and Information Management

Considerations/Questions	Description/Examples
11.1 How is information shared between FSC and HCC?	Information should be shared through regular updates using designated communication channels to ensure that the Family Support Center receives timely, accurate, and validated information from the Hospital Command Center. The use of radios (ensuring headsets), runners, or other technologies (Webex) may be used to share information. Patient lists, if on paper, should be updated between the ED, HCC, and FSC at regular intervals, optimally every 30 minutes.
11.2 Who approves information release?	All information released externally or to families should be approved by the Incident Commander and Public Information Officer to ensure accuracy, consistency, and compliance with policy.
11.3 How are family briefings conducted?	Family briefings should be conducted on a scheduled basis, such as every 30 to 60 minutes, and should provide consistent, clear, and updated information to those waiting for news about their loved ones. *Consider having a senior leader/executive provide these updates and ensure a clinical leader (CMO/CNO) accompanies them.
11.4 How is consistency ensured?	Consistency should be ensured by using standardized scripts, centralized messaging, and oversight by the Public Information Officer to prevent conflicting or inaccurate information.
11.5 How is the call center structured?	The call center should be staffed by dedicated personnel, such as Parallon or other designated teams, who utilize approved scripts and tracking tools to manage inquiries and provide accurate information.
11.6 How is misinformation managed?	Misinformation related to family support should be actively monitored, particularly on social media, and corrected promptly through coordinated messaging led by the Public Information Officer.



12. Privacy, Legal, and HIPAA

Considerations/Questions	Description/Examples
12.1 What info can be shared under HIPAA?	Information that may be shared under HIPAA should generally be limited to a patient’s location and general condition (e.g. stable, critical, deceased), in accordance with regulatory allowances during emergency situations. However, sharing of specific information for purposes of family reunification is allowed under HIPAA. ²
12.2 How is consent handled?	Consent should be obtained when possible; however, when a patient is unavailable or incapacitated, staff should use professional judgment to determine whether sharing information is in the patient’s best interest.
12.3 What can be shared with non-family?	Information shared with non-family members should be limited to basic status updates and should not include protected health information.
12.4 How is PHI protected?	Protected health information should be safeguarded through controlled access, staff training on privacy requirements, and secure handling of all documentation and communication.
12.5 How are disclosures coordinated?	Disclosures should be coordinated through the Hospital Command Center and Public Information Officer to ensure compliance with policy and consistency across all communications.

² HIPAA and Disasters: What Emergency Professionals Need to Know - information can be collected that aids in the reunification of families and patients.
<https://files.asprtracie.hhs.gov/documents/aspr-tracie-hipaa-emergency-fact-sheet.pdf>



13. Fatality Management

Considerations/Questions	Description/Examples
13.1 Who performs death notifications?	Death notifications should ideally be conducted by a multidisciplinary team that includes a physician or medical examiner representative, law enforcement personnel, chaplaincy, and behavioral health staff to ensure that notifications are delivered in a coordinated, compassionate, and supportive manner.
13.2 How is medical examiner coordination handled?	Coordination with the medical examiner should ensure official identification of decedents. Authorization for viewing, release of belongings, and release of body should be obtained as criminal investigations may limit usual processes. All actions should align with jurisdictional requirements and legal processes.
13.3 What team supports notifications?	A structured Death Notification Team should ideally be established to ensure that all notifications are conducted consistently, appropriately, and with adequate emotional and logistical support for families. Ideally, these are performed at the community Family Assistance Center unless the death occurs at the hospital.
13.4 Where are notifications conducted?	Notifications should be conducted in a private and controlled environment that ensures confidentiality, dignity, and emotional safety for those receiving the information.
13.5 How is family viewing managed?	Family viewing should be managed in a secure location where staff are present to provide support, ensure safety, and confirm that appropriate medical and emotional resources are available during the process and that medical examiner instructions are followed.
13.6 How are personal effects handled?	Personal effects should be secured and held until they are cleared for release by the medical examiner or law enforcement, ensuring compliance with legal and investigative requirements.
13.7 Who is responsible for morgue operations?	You may need to designate someone as morgue operations leader. Ensure extensive consideration has gone into the selection of this individual as the disposition and mental capacity of this person needs to be taken into consideration. Subsequently, have a plan for additional bodies as many morgues have limited capacity.



14. External Coordination

Considerations/Questions	Description/Examples
14.1 What agencies support FAC?	External agencies that support FAC operations include local emergency management, law enforcement, the American Red Cross, and healthcare coalitions, all of which contribute to coordinated response efforts.
14.2 How is coordination initiated?	Coordination with external partners should be initiated through designated roles such as the Liaison Officer or Intelligence Section, ensuring timely communication and integration of resources. Sharing of patient lists is critical, as additional families come forward with information/seeking family members.
14.3 How is information shared?	Information should be shared through regular coordination calls, established communication channels, and shared systems to maintain situational awareness across all partners.
14.4 How is transition to a Family Assistance Center managed?	Transition to a Family Assistance Center should be managed through a planned handoff process that includes transfer of documentation, coordination with external agencies, and clear communication of roles and responsibilities. There may be a period of overlap between FSC and FAC operations, but the goal is to rapidly reunify families with inpatients. Once the FAC opens, the FSC should begin a demobilization process which is often staged.
14.5 How are state/federal resources integrated?	State and federal resources should be integrated through coordination with State Emergency Operations Centers and healthcare coalitions to ensure access to additional support and capabilities.
14.6 How are investigations coordinated?	Investigations should be conducted by law enforcement agencies, with the FSC providing support and coordination as needed to ensure alignment with operational and investigative priorities. Interviews and investigations should not take place at the FSC, though some of these activities may be appropriate for a FAC.



15. Demobilization

Considerations/Questions	Description/Examples
15.1 What are demobilization criteria?	Demobilization should occur when all families have been accounted for, a Family Assistance Center is operational, or when overall demand for FSC services has decreased and may be managed through daily operations processes.
15.2 How is transition to a Family Assistance Center executed?	Transition should be executed through coordinated transfer of responsibilities to community partners, ensuring continuity of services and communication.
15.3 How are families informed?	Families should be informed through clear, direct communication regarding next steps and available resources, and this communication may best be delivered by facility leadership.
15.4 What documentation is required?	All logs, forms, and reports generated during FSC operations should be finalized and retained to support documentation, review, and compliance requirements.
15.5 How are staff released?	Staff should be released in an orderly manner following demobilization procedures, including debriefing and transition of responsibilities.
15.6 How are resources reset?	Resources should be reset by replenishing supplies, restoring spaces to normal operations, and preparing for future incidents.
15.7 What continuity exists?	Continuity should be maintained by providing families with ongoing contact points and resources to support continued assistance after FSC operations conclude.



16. Training and Exercises

Considerations/Questions	Description/Examples
16.1 What pre-incident training is required?	Staff should receive role-specific training prior to incidents to ensure they understand their responsibilities and can effectively support FSC operations.
16.2 What just-in-time training materials exist?	Just-in-time training materials such as quick reference guides and one-pagers should be readily available to support staff during activation.
16.3 How often is plan updated?	The FSC plan should be reviewed annually and updated following exercises or real-world incidents to incorporate lessons learned.
16.4 How are partners included?	External partners should be included in joint exercises and planning efforts to ensure coordination and interoperability during actual incidents.



Additional Resources: Family Support Center & Reunification Operations

For further guidance and best practices related to FSC operations, family reunification, and disaster family assistance, the following resources are recommended:

ASPR TRACIE

- **Family Reunification and Support Topic Collection**
<https://asprtracie.hhs.gov/technical-resources/65/family-reunification-and-support/0>
 - **Tips for Health Care Facilities: Assisting Families and Loved Ones After a Mass Casualty Incident**
<https://files.asprtracie.hhs.gov/documents/aspr-tracie-family-assistance-center-fact-sheet.pdf>
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Federal / National Guidance

- **National Center for Missing & Exploited Children (Disaster Response Resources)**
<https://www.missingkids.org>
 - **American Red Cross – Safe and Well / Reunification Services**
<https://www.redcross.org/get-help/disaster-relief-and-recovery-services/contact-and-locate-loved-ones.html>
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Healthcare & Emergency Management

- **Healthcare Coalition Resources (HHS/ASPR)**
<https://aspr.hhs.gov/Pages/Home.aspx>
 - **Joint Commission Emergency Management Standards (Family Support Considerations)**
<https://www.jointcommission.org>
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Behavioral Health & Psychological First Aid

- **SAMHSA Disaster Distress Helpline & Resources**
<https://www.samhsa.gov/find-help/disaster-distress-helpline>
 - **Psychological First Aid Field Operations Guide (NCTSN)**
[All NCTSN Resources | The National Child Traumatic Stress Network](https://www.nctsn.org/)
<https://www.nctsn.org/>
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Appendix: Signage



FAMILY SUPPORT CENTER Sign In



QUIET AREA

RECEPTION AREA

WAITING AREA



Appendix: Staff Sign in Sheet

Staff Sign in Sheet

First Name	Last Name	Assignment Location	Training Received?	Check In			Check Out		
				Date	Time	Initials	Date	Time	Initials
John	Doe	Waiting Area	Yes	XX/XX/XXXX	XX:XX	JD	XX/XX/XXXX	XX:XX	JD



Appendix: Supplies and Equipment

Supplies and Equipment

- Computers (computer on wheels)
- Interpreter iPad on wheels
- Printer / copier
- Signage
- Phones
- Radios
- Copies of the FSC Plan
- List of outside resources that can be provided to family members

Office supplies:

- Staplers, staples, staple remover
- Paper clips
- Pencils, pens, highlighters
- Folders
- Paper, note pads, post-it notes
- Masking tape
- Scotch tape
- Scissors
- Clipboards

Forms:

- Signs
- Site Flow Pattern
- Staff Sign in Sheets
- Family Sign in Sheets
- Unaccompanied Minor Registration and Tracking Form
- Unidentified person's form

Other:

- Tissues
- Trash cans
- Hand sanitizer
- Toys, paper, crayons, markers
- Blankets
- Snacks and water
- Cups and napkins
- Cell phone chargers
- Extension cords with surge strips
- Plain t-shirts/paper scrubs (as friends and family members may have transported their loved ones to the hospital in their own POV).

Appendix: Map/Flow Consideration

