Coastal Health District Functional and Medical Needs Evacuation Registration Form

**Note: Please PRINT the entire form and mail it to your county health department. Registration must be updated and submitted annually.**

Important Notes

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In an actual emergency, coordinating agencies will try to provide the necessary evacuation assistance, but this cannot always be assured.

* To best guarantee personal safety, individuals should make plans and follow government emergency evacuation guidelines.
* A personal caregiver **SHOULD** accompany you to the emergency shelter. The caregiver **MUST** be able to provide the same care at the shelter as is delivered at home. This may be for an extended period, 4-7 days or longer, depending on the event.
* Depending on your health status you may be transported to an American Red Cross emergency shelter or admitted to an inland healthcare facility.
* Shelters will provide no more than 20-40 square feet of space. (example: a cot with 1-2 feet of walk around space)
* Nursing Homes, Assisted Living Facilities, Personal Care Homes and In-patient Hospice facilities are responsible for the evacuation of their residents. Residents living in a nursing home, assisted living facility or personal care home **MUST** follow the emergency plan established by the facility’s administration.
* Residents under the care of in-home Hospice and Home Health Care Agencies should work with their providers to establish an emergency plan. This includes pre-determined destination and contact Information.
* There may be a cost associated with care or transportation if the client is placed in a healthcare facility

Coastal Health District Functional and Medical Needs Evacuation Registration Form

**Note: Please PRINT the entire form and mail it to the return address at the end of the form. Registration must be updated and submitted annually.**

 Required Personal Enrollment Data
 Section 1 (One Person Per Form)

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**Date of Application**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **New Application**   **Updated (of existing application)**

**Name:**
Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex**:  Male  Female **Tracking Number (for official use only)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street address**:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Street City State Zip Apt. County

**Mailing address (if different from above**):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 City State Zip

**Primary phone**: \_\_\_\_\_\_\_\_\_\_\_\_ **Alt. phone**: \_\_\_\_\_\_\_\_\_\_\_\_  Client Hearing Impaired, Telecommunication Service Required

**Date of Birth**: \_\_\_ / \_\_\_ / \_\_\_\_\_\_ **Age**: \_\_\_\_\_\_ **Weight**: \_\_\_\_\_\_\_\_ lbs. **Height:** \_\_\_\_\_\_\_\_ ft. \_\_\_\_\_\_\_\_ In.

**Primary language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level of English proficiency, if English is not primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Residence type**:  Single family home/duplex  Mobile home park/trailer  Apt. /Condo

  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of subdivision, mobile home park, or apartment complex \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Residents living in nursing homes, assisted living facilities, and personal care homes MUST follow the emergency plan established by the facility’s administration.**

**Living situation**:

 Living alone  Living with parents  Living with children/family  Living with friend

 Living with spouse  Spouse also on the registry  other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of contact in home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Filling out Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 2 Emergency Contacts

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**(Local) Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

  **Phone**: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**(Non-Local) Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationshi**p: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

 **Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

(**Other) Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationshi**p: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

 **Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Section 3 Functional Needs

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**Check all that apply:**

 Walker  Cognitive Impairment  Speech Impairment  Service Animal
 Cane  Anxiety/Depression  Vision Loss/Impaired  Allergies to Foods

 Wheelchair  Mental Health Problem  Hearing Loss/Impaired  Dietary Restrictions

 Bedridden  Alzheimer’s/Dementia  Communication aids/services  Morbid Obesity

List any additional devices \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of daily living require:**
 Durable medical equipment (DME) (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Consumable medical supplies (CMS) (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Personal Assistance Services (PAS) (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Oxygen Company (Provider Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Assistance with medications  Medications require refrigeration

**Sleeping accommodations**

  Accessible cots  Crib  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Access to transportation:**
 Wheelchair accessible vehicle  Individualized assistance  Transportation of equipment required

**Assistance with activities of daily living:**
 Eating  Taking medication  Dressing/undressing  Walking  Stabilization  Climb Stairs
 Transferring to/from wheelchair or other mobility aid  Bathing  Toileting  Communicating

Section 4 Medical Needs

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**Check all that apply:**
 IV medication  Dialysis  Insulin Dependent Diabetes
 Requires medical observation  Open wounds/decubitus  Assistance with Meds Including Insulin
 Respirator dependent  Hypertension  Immune deficiency
 Chronic respiratory condition  Incontinence  Unstable

 Oxygen required (Please add flow rate L / min and tank size to notes)

Medical dependence on electricity  Yes  No

  O2 concentrator  Nebulizer  Feeding Pump  Suction  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dependent on power operating equipment to sustain life (Please add supporting information to notes)

 Medical Diagnosis: (i.e. insulin dependent diabetes, dialysis, hypertension, Chronic respiratory Conditions) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requires licensed care provider to perform the following: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Terminal  Contagious condition  Ongoing treatment Please (Please add info on any of the previous conditions)

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 5 Medications

Z9One

**Please list your current medication(s):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 6 Additional Required Information

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 A caregiver SHOULD travel with registrant. Do you have a caregiver?  Yes  No
 Caregiver name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caregiver mobile phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
 Will your caregiver travel with you?  Yes  No
 Do you have a pet or service animal that needs to travel with you?  Yes  No
 What type of service animal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 What type of pet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Do you have proof of vaccination for your pet?  Yes  No
 Do you have a carrier for your pet?  Yes  No
 Do you need transportation to the staging area (area from which evacuation will take place) in the event of a disaster?  Yes  No
 If yes, indicate type of transportation:  Bus  Wheelchair van  Ambulance

Section 7 Provider and Insurance Information

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Primary doctor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Home health agency name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Hospice provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Other health service provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Pharmacy name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Medicaid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Medicaid ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Waiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Medicare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Medicare ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Health Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
Insurance policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insurance group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Case manager (name and organization):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_
 E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This section to be completed by Coastal Health District.

Date Approved: \_\_\_\_\_\_\_\_\_ Date Updated: \_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_ Triage: \_\_\_\_\_\_\_\_\_ Status: \_\_\_\_\_\_

Destination Assignment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Facility Assignment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Consent to Participate in the Functional/Medical Needs Registry

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Please read and initial each of following. Refusal to sign does not mean you will not be placed on the Registry. It may, however, affect our ability to process this application **and** our ability to assist you.

\_\_\_\_\_ I recognize that neither the County Department of Public Health, County Emergency Management Agency, nor any of their partners are responsible for providing medical care for evacuees and that the intent of the Functional/Medical Needs Registry is to provide, to the extent possible under emergency conditions, an environment in which the current level of health of the evacuees with functional or medical needs can be sustained within the capabilities of available resources.

\_\_\_\_\_ I recognize that completion of this application does not guarantee my placement in the Functional/Medical Needs Registry, and that even if I am placed on the Registry, I remain responsible for myself in the event of a disaster.

\_\_\_\_\_ I assume responsibility for updating the County Functional/Medical Needs Coordinator regarding any changes in my medical status or contact information (phone number, address, etc.). Even if no changes in my status occur, I agree to contact the Coordinator at least annually.

\_\_\_\_\_ I am completing and submitting this application of my own free will.

\_\_\_\_\_ I give local law enforcement and emergency services personnel permission to enter my home in the event of an emergency.

\_\_\_\_\_ I authorize the contact of the person(s) I have listed herein as my emergency contact in the event of an emergency.

\_\_\_\_\_ I have read and signed the “Authorization for Release of Protected Health Information” form used to assist public health and their partners in facilitating my evacuation and sheltering needs during an emergency.

\_\_\_\_\_ I had the opportunity to ask questions regarding the use of my health information and obtain a Notice of Privacy Policy form upon request.

By signing this form, I agree that the information contained is accurate and truthful to the best of my knowledge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing this form:  Self  other (name and phone number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address/Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Please print and return to:
Long County Health Dept.
Attn: Kathy Rowell
P.O. Box 279
Ludowici, GA 31316**