

# Department of Public Health

## Coastal Health District Hurricane Registry Application

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

### Important Notes

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

Department of Public Health

Coastal Health District Hurricane Registry Application

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.

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

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/Room# \_\_\_\_\_ County \_\_\_\_\_

Mailing address (if different from above):

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Alternate 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: \_\_\_\_\_

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

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

Other (specify) \_\_\_\_\_

Name of subdivision, mobile home park, or apartment complex \_\_\_\_\_

Living situation:

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

Living with spouse  other (specify) \_\_\_\_\_

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

Name of Spouse (If Applicable) \_\_\_\_\_ Is Spouse Registered? \_\_\_\_\_

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

Relationship \_\_\_\_\_

## Section 2

## Emergency Contacts

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

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

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

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

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

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

## Section 3

## Functional Needs

Medical dependence on electricity  Yes  No If yes, check all that apply:

O2 concentrator  Nebulizer  Feeding Pump  Suction  Other (specify) \_\_\_\_\_

Additional Special Needs \_\_\_\_\_

### Check all that apply:

- Walker  Cognitive Impairment (specify) \_\_\_\_\_  Speech Impairment  Service Animal  
 Cane  Anxiety/Depression  Vision Loss/Impaired  Allergies to Foods  Wheelchair  
 Mental Health Problem(specify) \_\_\_\_\_  Hearing Loss/Impaired  Dietary Restrictions (specify) \_\_\_\_\_  
 Bedridden  Alzheimer's/Dementia  Communication aids/services  Morbid Obesity

What mode of transportation do you use for physician appointments? \_\_\_\_\_

How do you transfer from bed to chair? \_\_\_\_\_

How do you transfer from wheelchair? \_\_\_\_\_

Are you able to toilet yourself or do you need assistance? \_\_\_\_\_

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

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## 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

### 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 (flow rate L/M \_\_\_\_\_)  
 Dependent on power operating equipment to sustain life (Please specify \_\_\_\_\_)

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

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

- Terminal     Contagious condition, ex. Flu-like symptoms (specify \_\_\_\_\_)

- Ongoing treatment Please (Please add info on any of the previous conditions)

- Other
- \_\_\_\_\_
- \_\_\_\_\_

**Section 5 Medications**

Please list your current medication(s):

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Allergies:

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**Section 6 Additional Required Information**

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

**\*\*\*\*Pets cannot be sheltered at hospitals or transported in an ambulance. Arrangements will be made with animal services for pet sheltering\*\*\*\***

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**

Primary doctor name: \_\_\_\_\_

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

Home health agency name: \_\_\_\_\_

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

Hospice provider: \_\_\_\_\_

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

Other health service provider: \_\_\_\_\_

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

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Pharmacy name: \_\_\_\_\_  
Medicaid: \_\_\_\_\_  
Medicaid ID: \_\_\_\_\_  
Waiver: \_\_\_\_\_  
Medicare: \_\_\_\_\_  
Medicare ID: \_\_\_\_\_  
Health Insurance Company Name: \_\_\_\_\_  
Insurance policy # \_\_\_\_\_  
Insurance group # \_\_\_\_\_  
Case manager (name and organization):  
\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
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 Hurricane Registry

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:**

**Effingham County Health Dept.**

**Attn: Cindy Grovenstein**

**P.O. Box 350**

**Springfield, GA 31329**