Coastal Health District Hurricane Registry Application

Effingham County Health Department

Critical Information

The health departments in Georgia’s coastal counties keep a list of residents with certain healthcare needs who have no ability to leave home in an emergency. The Registry is ONLY for people who will need medical care or help with daily activities and have no other way to evacuate.

- To best guarantee personal safety, individuals should make plans and follow government emergency evacuation guidelines.

- Depending on your health status you may be transported to an American Red Cross emergency shelter or admitted to an inland healthcare facility.

- If you will be transported to an emergency shelter, one personal caregiver SHOULD accompany you to the shelter. The caregiver MUST be able to provide the same care at the shelter as is delivered at home and be over the age of 18. This may be for an extended period, 4-7 days or longer, depending on the event.

- If you are an individual with Medical Needs who will be admitted to an inland healthcare facility, caregivers and pets are not able to accompany you. Only trained service animals may come with you to a healthcare facility.

- A service animal is defined by the Americans with Disabilities Act as any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability.

- Pets, Emotional Support or Comfort Animals do not have specific training to perform tasks to assist people with disabilities and are not covered under ADA laws as service animals.
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   □ Update to an existing application

Name:
Last _________________________   First _________________________ Middle _________________________

Date of Birth: ___ / ___ / ______   Tracking Number (for official use only) ________________

Sex: □ Male   □ Female

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

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 _______________________________________________________

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 also on the Hurricane Registry? Y / N
A caregiver **SHOULD** travel with registrant if going to a shelter. 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 certified service animal that needs to travel with you?  □ Yes  □ No

****Pets cannot be sheltered at hospitals. Arrangements will be made with animal services for pet sheltering****

What type of certified 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

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**Section 2**  Emergency Contacts

**Name:** ________________________________  **Relationship:** ________________  **Phone:** (_____) _____-_______

Phone: (_____) _____-_______

**Name:** ________________________________  **Relationship:** ________________  **Phone:** (_____) _____-_______

Phone: (_____) _____-_______

**Name:** ________________________________  **Relationship:** ________________  **Phone:** (_____) _____-_______

Phone: (_____) _____-_______

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**Section 3**  Functional Needs

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 use the bathroom without assistance?  □ Yes  □ No

List any additional devices ____________________________________________________________

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

□ O2 concentrator  □ Nebulizer  □ Feeding Pump  □ Suction  □ Other (specify)___________________________

Additional Special Needs__________________________________________________________
Department of Public Health

Check all that apply:

☐ Walker  ☐ Wheelchair  ☐ Cane  ☐ Cognitive Impairment (specify)______________
☐ Anxiety/Depression  ☐ Vision Loss/Impaired  ☐ Speech Impairment (specify)________
☐ Mental Health Problem(specify)____________________  ☐ Hearing Loss/Impaired  ☐ Dialysis
☐ Bedridden  ☐ Alzheimer’s/Dementia  ☐ Communication aids/services  ☐ Morbid Obesity
☐ Insulin Dependent Diabetes  ☐ Allergies to Foods  ☐ Dietary Restrictions (specify)______________
☐ Requires medical observation  ☐ Open wounds/decubitus (specify)____________________
☐ Hypertension  ☐ Immune deficiency  ☐ Respirator dependent  ☐ Incontinence
☐ Chronic respiratory condition  ☐ Unable to walk/stand without assistance  ☐ Service Animal
☐ Oxygen required (flow rate L/M ________________)

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 (specify)__________________________

Sleeping accommodations

☐ Accessible cots  ☐ Crib  ☐ Bariatric bed (>500lbs)  ☐ 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

Check all that apply:

☐ 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. Tuberculosis or Hepatitis A (specify___________________________)
☐ Ongoing treatment (Please add info on any of the previous conditions)

☐ Other
___________________________________________________________________________________________________
___________________________________________________________________________________________________
### Section 4  Provider and Insurance Information

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<thead>
<tr>
<th>Information</th>
<th>Phone: (<em><strong>) <em><strong>-</strong></em></strong></em></th>
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<tbody>
<tr>
<td>Primary doctor name</td>
<td>________________________</td>
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<tr>
<td>Home health agency name</td>
<td>________________________</td>
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<tr>
<td>Hospice provider</td>
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<tr>
<td>Other health service provider</td>
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<td>Pharmacy name</td>
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<td>Medicaid ID</td>
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<td>Medicare ID</td>
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<td>Medicare Supplemental</td>
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<td>Health Insurance Company Name</td>
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<td>Insurance policy #</td>
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<td>Insurance group #</td>
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<td>Case manager (name and organization):</td>
<td>________________________</td>
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<tr>
<td>Person Filling out Form</td>
<td>________________________</td>
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<tr>
<td>Relationship</td>
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### Section 5  Medications

Please list your current medication (Names and Dosage):

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Allergies:

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Person Filling out Form ________________________________ Phone ________________

Relationship ________________________________

Registrant Signature ________________________________ Date: ________________
PLEASE READ AND INITIAL EACH OF FOLLOWING:

_____ I understand the purpose of the Functional/Medical Needs Registry is to assist in facilitating my evacuation and placement needs during an actual or pending emergency or disaster in which I am being asked to evacuate.

_____ I understand that residents under the care of in-home Hospice and Home Health Care Agencies should work with their providers to create a primary emergency plan. This includes pre-determined destination and contact information.

_____ I understand that an American Red Cross emergency shelter will provide no more than 20-40 square feet of space. (example: a cot with 1-2 feet of walk around space)

_____ I understand that every effort will be made to facilitate my placement and transportation needs. However, I understand the extent of the emergency or disaster may result in an inability to place me.

_____ I understand that There may be a cost associated with care or transportation if the client is placed in a healthcare facility

_____ I understand it is my responsibility to update this form as needed. I will contact the health department annually to confirm my information.

_____ I understand that, even if I’m placed on the Registry, I can still refuse transportation. A refusal form stating I assume all risks associated with my refusal will be provided to me for signature.

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

_____ I have received the Health Department’s Notice of Privacy Practices.

Signature: ________________________________________     Date: ______________________________
Name (printed): ________________________________________
Person completing this form: □ Self □ other (name and phone number): ______________________________
Address/Company: _____________________________________ Phone: (_____) ______-________

When the Application & Consent form and the Protected Health Information authorization forms have been completed, please take them to your health department, mail, or fax them to:

Effingham Co. Health Dept.
Attn: Cindy Grovenstein, R.N.
P.O. Box 350
Springfield, GA 31329
FAX: 912-754-7623