Department of Public Health

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.**

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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

Section 2 Emergency Contacts

Name: _________________________________ **Relationship**: _________________ **Phone**: (_____) ______-_________

Phone: (_____) ______-_________

Name: _________________________________ **Relationship**: _________________ **Phone:** (_____) ______-_________

Phone: (_____) ______-_________

Name: _________________________________ **Relationship**: _________________ **Phone:** (_____) ______-_________

Phone: (_____) ______-_________

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____

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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

Primary doctor name: ____ Phone: (_____) ______-________
Home health agency name: ___________________________________ Phone: (_____) ______-________
Hospice provider: _______________________________________ Phone: (_____) ______-________
Other health service provider: ___________________________________ Phone: (_____) ______-________
Pharmacy name: ____ Phone: (_____) ______-________

Medicaid ID: ____

Medicare ID: ____ Phone: (_____) ______-________
Medicare Supplemental: _____________________________ Phone: (_____) ______-________
Health Insurance Company Name: ________________________________ Phone: (_____) ______-________
Insurance policy # ____
Insurance group # ____
Case manager (name and organization):
____ Phone: (_____) ______-________
E-mail _______________________

Section 5 Medications

Please list your current medication (Names and Dosage):

____
____
____
____

Allergies:

____
____
____
____

Person Filling out Form _______________________________________ **Phone**_________________

Relationship ______________________________

Registrant Signature ____ **Date:** ______________________

Department of Public Health

Consent to Participate in the Hurricane Registry

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