

## Department of Public Health

### Coastal Health District Hurricane Registry Application

#### Glynn 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

# Department of Public Health

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 \_\_\_\_\_

# 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**

Primary doctor name: \_\_\_\_\_  
Home health agency name: \_\_\_\_\_  
Hospice provider: \_\_\_\_\_  
Other health service provider: \_\_\_\_\_  
Pharmacy name: \_\_\_\_\_

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

Medicaid ID: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
E-mail \_\_\_\_\_

**Section 5 Medications**

**Please list your current medication (Names and Dosage):**

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

**Allergies:**

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

<b>Person Filling out Form</b> _____	<b>Phone</b> _____
<b>Relationship</b> _____	
<b>Registrant Signature</b> _____	<b>Date:</b> _____

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:**

**Glynn Co. Health Department  
Attn: Adam Sanchez  
2747 Fourth Street  
Brunswick, GA 31520  
FAX: 912-279-3349**