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.

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______________________________________________
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: _______________________________________  Phone: (_____) ______-________
Home health agency name: __________________________________ Phone: (_____) ______-________
Hospice provider: ______________________________________  Phone: (_____) ______-________
Other health service provider: __________________________________  Phone: (_____) ______-________
Pharmacy name: _____________________________________________  Phone: (_____) ______-________

Medicaid ID: ________________________________________________

Medicare ID: _______________________________________________  Phone: (_____) ______-________
Medicare Supplemental: ___________________________________________
Health Insurance Company Name: ________________________________  Phone: (_____) ______-________
Insurance policy # ____________________________________________  Phone: (_____) ______-________
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: _____________________
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