Department of Public Health

Coastal Health District Hurricane Registry Application

Long 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

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_____

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:

Long County Health Dept.
Attn: Lisa Palmer, R.N.
P.O. Box 279
Ludowici, GA 31316
FAX: 912-545-2112