Access and Functional Needs - Special Medical Needs Registry

What type of assistance are you interested in? ☐ Wellness Check ☐ Evacuation Assistance

Who are you completing this form for? ☐ Myself ☐ Someone else

Personal Information

First Name_____ Middle Name_____ Last Name_____

Date of Birth_____ Gender ☐Male ☐Female

Address _____

City_____ State_____Zip _____

Home Phone_____ Alt. Phone_____ TTY/TDD Line_____

Email Address _____

Emergency Contact Information

Primary Contact_____ Relationship_____

Home Phone_____ Cell Phone_____ Work Phone _____

Address _____

City_____ State_____ Zip _____

Email Address _____

Medical Information Permission? ☐Yes ☐No

Secondary Contact_____ Relationship _____

Home Phone_____ Cell Phone_____ Work Phone _____

Address _____

City_____ State_____ Zip _____

Email Address _____

Medical Information Permission? ☐Yes ☐No

Medical Provider Information

Primary Physician_____ Phone _____

Pharmacy_____ Phone _____

Oxygen Provider_____ Phone _____

Home Health Agency_____Phone _____

Medical Needs/Information

Please check the box beside the tasks that you are unable to complete without assistance.

☐Eating ☐Grooming ☐Dressing ☐Bathing ☐Toileting

If you selected a box above, do you have a caregiver to assist you with these tasks? ☐Yes ☐No

If you have a caregiver, please complete the following information:

Caregiver Name _____

Relationship _____

Phone Number _____

Address _____

City_____ State_____ Zip _____

Living Arrangements:

☐Alone ☐Relative ☐Caregiver ☐Other_____

Language/Communication:

☐Deaf ☐Hard of Hearing ☐Speech-Impaired ☐Does not speak English

Mobility Impairments:

☐Bedridden ☐Wheelchair ☐Walker/Cane

Special Medical Equipment Required:

☐Oxygen ☐Suction ☐Feeding Pump ☐Dialysis ☐Other_____

Sight Impairments:

☐Blind ☐Other _____

Cognitive Impairments:

☐Mentally/Memory Impaired ☐Dementia ☐Alzheimer's ☐Psychosis ☐Autism

☐Other _____

I have the following conditions: (check all that apply)

☐Cardiac ☐Cerebral Palsy ☐COPD ☐Cystic Fibrosis

☐Diabetes ☐Seizures ☐Neuro-muscular disorder ☐None

☐Other _____

My Personal Disaster Plan

☐I do not have a plan

☐I plan to shelter at home

☐I plan to utilize the local shelter

☐I plan to evacuate or shelter with family/friend

Family/Friend Name _____

Relationship _____

Phone Number _____

Address where you will evacuate/shelter_____

City_____ State_____ Zip _____

Transportation

☐ I will transport myself

☐ I have someone to transport me

☐ I need assistance with transportation

My Pets Disaster Plan

Do you have any pets? ☐Yes ☐No

Pets are not allowed at the shelters. Accommodations may be made to house pets at the BC Animal Services Shelter

Do you have a service animal? ☐Yes ☐No

Disaster plan for my pets _____

_____

_____

Applicant Signature & Health Insurance Portability and Accountability Act (HIPAA)

I certify that this information is correct. I understand that based on this application and the data I have provided, Beaufort County Emergency Services will determine which emergency and evacuation assistance, if any, this program may be able to provide. I understand that there is no cost associated with using any of the County's disaster evacuation centers. I grant permission to medical providers, transportation agencies, and other individuals providing me with assistance and disclose any information required to respond to my needs. I understand that I have the right to revoke this Authorization at any time, except to the extent that Beaufort County has already acted in reliance on the Authorization.

To revoke this Authorization, I understand that I must do so by written request to the Beaufort County Office of Emergency Services, 1420 Highland Dr, Washington, NC, 27889. Attention: Special Medical Needs Registry.

HIPAA Privacy Rule:

As defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule of 1996, by signing this Authorization, I hereby allow the use or disclosure of my medical information by Beaufort County in order to provide me with assistance during emergency evacuations. I understand that information used or disclosed pursuant to this Authorization may be subject to disclosure by the recipient for the purposes of evacuation, sheltering, transportation, and any medical care pursuant to these services.

Signature of Applicant: _____ Date:_____

Name of person completing this application:

Name: _____ Phone: (_____) _____-_____

Please complete and return this form to:

Beaufort County Emergency Services
Attn: Special Medical Needs Registry
1420 Highland Drive
Washington, NC 27889

BEAUFORT COUNTY, N.C.

OFFICE OF EMERGENCY SERVICES

1420 Highland Dr
Washington, NC 27889

Phone: (252) 946-2046 **Fax:** (252) 975-6802

Access and Functional Needs - Special Medical Needs Registry
Beaufort County

The Access and Functional Needs Registry is made for individuals who require assistance with evacuation and sheltering during an emergency. Residents of long-term care facilities **do not** qualify for this program because these businesses must have their own emergency plans for their clients. Individuals meeting one of the following categories are encouraged to participate in this registry:

- Those who require specialized transportation and/or have no transportation
- Those whose medical needs prevent them from evacuating/sheltering on their own

Please take into consideration the following:

- Do not provide information that you believe would compromise your security.
- **Do not wait until an evacuation order is given to request being added to the Registry.**
- **Due to a limited number of staff, we recommend that a caregiver accompany you and remain with you during your stay at the shelter.**
- Be as complete as possible in your responses.
- You may be emailed periodically to verify and ensure the information provided is correct and to make any necessary changes, but we encourage you to edit your information at any point when your data changes.
- Entering data in this registry does not guarantee that a specific emergency situation will be handled in any particular order or manner.

The first line of defense against the effects of a disaster is personal preparedness. During an emergency, the government and other agencies may not be able to meet your needs. It is important for all citizens to make their own emergency plans and prepare for their own care and safety in an emergency. Submitting your information to this registry is not a guarantee that emergency officials will be able to assist you in an emergency.