Department of Public Health

Coastal Health District Hurricane Registry Application

Note: Please PRINT the entire form and mail it to your county health department. Registration must be updated and submitted annually.

Important Notes

In an actual emergency, coordinating agencies will try to provide the necessary evacuation assistance, but this cannot always be assured.

- To best guarantee personal safety, individuals should make plans and follow government emergency evacuation guidelines.
- A personal caregiver **SHOULD** accompany you to the emergency shelter. The caregiver **MUST** be able to provide the same care at the shelter as is delivered at home. This may be for an extended period, 4-7 days or longer, depending on the event.
- Depending on your health status you may be transported to an American Red Cross emergency shelter or admitted to an inland healthcare facility.
- Shelters will provide no more than 20-40 square feet of space. (example: a cot with 1-2 feet of walk around space)
- Nursing Homes, Assisted Living Facilities, Personal Care Homes and In-patient Hospice facilities are responsible for the evacuation of their residents. Residents living in a nursing home, assisted living facility or personal care home **MUST** follow the emergency plan established by the facility's administration.
- Residents under the care of in-home Hospice and Home Health Care Agencies should work with their providers to establish an emergency plan. This includes pre-determined destination and contact Information.
- There may be a cost associated with care or transportation if the client is placed in a healthcare facility

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** ☐ **Updated (of existing application)**

Name:
Last _____ First _____ Middle _____

Sex: ☐ Male ☐ Female **Tracking Number (for official use only)** _____

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

Date of Birth: ___ / ___ / _____ **Age**: _____ **Weight**: _____ lbs. **Height:** _____ ft. _____ In.

Primary language: _____ Level of English proficiency, if English is not primary: _____

*** Residents living in nursing homes, assisted living facilities, and personal care homes MUST follow the emergency plan established by the facility's administration.**

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 Registered? _____

Person Filling out Form _____ Phone_____

Relationship _____

Section 2 Emergency Contacts

Name: _____ **Relationship**: _____ **Phone**: (_____) _____-_____

Phone: (_____) _____-_____

Name: _____ **Relationshi**p: _____ **Phone:** (_____) _____-_____

Phone: (_____) _____-_____

Name: _____ **Relationshi**p: _____ **Phone:** (_____) _____-_____

Phone: (_____) _____-_____

Section 3 Functional Needs

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 ☐ Cognitive Impairment (specify)_____ ☐ Speech Impairment ☐ Service Animal
☐ Cane ☐ Anxiety/Depression ☐ Vision Loss/Impaired ☐ Allergies to Foods ☐ Wheelchair
☐ Mental Health Problem(specify)_____ ☐ Hearing Loss/Impaired ☐ Dietary Restrictions (specify)_____
☐ Bedridden ☐ Alzheimer's/Dementia ☐ Communication aids/services ☐ Morbid Obesity
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 toilet yourself or do you need assistance? _____
List any additional devices _____
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

Sleeping accommodations

☐ Accessible cots ☐ Crib ☐ 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

Section 4 Medical Needs

Check all that apply:

☐ IV medication ☐ Dialysis ☐ Insulin Dependent Diabetes
☐ Requires medical observation ☐ Open wounds/decubitus ☐ Assistance with Meds Including Insulin
☐ Respirator dependent ☐ Hypertension ☐ Immune deficiency
☐ Chronic respiratory condition ☐ Incontinence ☐ Unstable
☐ Oxygen required (flow rate L/M _____)

☐ 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. Flu-like symptoms (specify_____)
☐ Ongoing treatment Please (Please add info on any of the previous conditions)

☐ Other

_____

_____

Section 5 Medications

Please list your current medication(s):

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

Section 6 Additional Required Information

A caregiver **SHOULD** travel with registrant. 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 service animal that needs to travel with you? ☐ Yes ☐ No

******Pets cannot be sheltered at hospitals or transported in an ambulance. Arrangements will be made with animal services for pet sheltering******

What type of 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
Do you need transportation to the staging area (area from which evacuation will take place) in the event of a disaster?
☐ Yes ☐ No
If yes, indicate type of transportation: ☐ Bus ☐ Wheelchair van ☐ Ambulance

Section 7 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: _____ Phone: (_____) _____-_____
Medicaid ID: _____
Waiver: _____ Phone: (_____) _____-_____
Medicare: _____ Phone: (_____) _____-_____
Medicare ID: _____ Phone: (_____) _____-_____
Health Insurance Company Name: _____ Phone: (_____) _____-_____
Insurance policy # _____
Insurance group # _____
Case manager (name and organization):
_____ Phone: (_____) _____-_____
E-mail _____

This section to be completed by Coastal Health District.

Date Approved: _____ Date Updated: _____ County:_____ Triage: _____ Status: _____

Destination Assignment: _____

Medical Facility Assignment: _____

Consent to Participate in the Hurricane Registry

Please read and initial each of following. Refusal to sign does not mean you will not be placed on the Registry. It may, however, affect our ability to process this application **and** our ability to assist you.

_____ I recognize that neither the County Department of Public Health, County Emergency Management Agency, nor any of their partners are responsible for providing medical care for evacuees and that the intent of the Functional/Medical Needs Registry is to provide, to the extent possible under emergency conditions, an environment in which the current level of health of the evacuees with functional or medical needs can be sustained within the capabilities of available resources.

_____ I recognize that completion of this application does not guarantee my placement in the Functional/Medical Needs Registry, and that even if I am placed on the Registry, I remain responsible for myself in the event of a disaster.

_____ I assume responsibility for updating the County Functional/Medical Needs Coordinator regarding any changes in my medical status or contact information (phone number, address, etc.). Even if no changes in my status occur, I agree to contact the Coordinator at least annually.

_____ I am completing and submitting this application of my own free will.

_____ I give local law enforcement and emergency services personnel permission to enter my home in the event of an emergency.

_____ I authorize the contact of the person(s) I have listed herein as my emergency contact in the event of an emergency.

_____ I have read and signed the "Authorization for Release of Protected Health Information" form used to assist public health and their partners in facilitating my evacuation and sheltering needs during an emergency.

_____ I had the opportunity to ask questions regarding the use of my health information and obtain a Notice of Privacy Policy form upon request.

By signing this form, I agree that the information contained is accurate and truthful to the best of my knowledge.

Signature: _____ Date: _____

Name (printed): _____

Person completing this form: ☐ Self ☐ other (name and phone number): _____
Address/Company: _____ Phone: (_____) _____-_____

Please print and return to your local health department.