Department of Public Health

Coastal Health District Functional and Medical Needs Evacuation Registration Form

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

Department of Public Health

Coastal Health District Functional and Medical Needs Evacuation Registration Form

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. County

Mailing address (if different from above):

____
City State Zip

Primary phone: ____________ **Alt. 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: _____________________

Residence type: ☐ Single family home/duplex ☐ Mobile home park/trailer ☐ Apt. /Condo
☐ Other (specify) ____
Name of subdivision, mobile home park, or apartment complex ____

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

Living situation:

☐ Living alone ☐ Living with parents ☐ Living with children/family ☐ Living with friend

☐ Living with spouse ☐ Spouse also on the registry ☐ other (specify) ____

Name of contact in home: _____________________________ Phone: _____________________

Name of Spouse (If Applicable) ____

Person Filling out Form _______________________________________ Phone________________

Relationship ______________________________

Section 2 Emergency Contacts

(Local) Name: ________________________________ **Relationship**: ________________ **Phone**: (_____) ______-________

Phone: (_____) ______-________

(Non-Local) Name: _____________________________ **Relationship**: ________________ **Phone:** (_____) ______-________

Phone: (_____) ______-________

(**Other) Name**: _________________________________ **Relationship**: _______________ **Phone:** (_____) ______-________

Phone: (_____) ______-________

Section 3 Functional Needs

Check all that apply:

☐ Walker	☐ Cognitive Impairment	☐ Speech Impairment	☐ Service Animal
☐ Cane	☐ Anxiety/Depression	☐ Vision Loss/Impaired	☐ Allergies to Foods
☐ Wheelchair	☐ Mental Health Problem	☐ Hearing Loss/Impaired	☐ Dietary Restrictions
☐ Bedridden	☐ Alzheimer's/Dementia	☐ Communication aids/services	☐ Morbid Obesity

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
- ☐ Requires medical observation
- ☐ Respirator dependent
- ☐ Chronic respiratory condition
- ☐ Dialysis
- ☐ Open wounds/decubitus
- ☐ Hypertension
- ☐ Incontinence
- ☐ Insulin Dependent Diabetes
- ☐ Assistance with Meds Including Insulin
- ☐ Immune deficiency
- ☐ Unstable
- ☐ Oxygen required (Please add flow rate L / min and tank size to notes)

Medical dependence on electricity ☐ Yes ☐ No

☐ O2 concentrator ☐ Nebulizer ☐ Feeding Pump ☐ Suction ☐ Other ______________________________________

☐ Dependent on power operating equipment to sustain life (Please add supporting information to notes)

☐ Medical Diagnosis: (i.e. insulin dependent diabetes, dialysis, hypertension, Chronic respiratory Conditions)

____

____

Requires licensed care provider to perform the following: ______________________________________

☐ Terminal ☐ Contagious condition ☐ 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
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: ____

Department of Public Health

Consent to Participate in the Functional/Medical Needs 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:
Effingham County Health Dept.
Attn: Cindy Grovenstein
P.O. Box 350
Springfield, GA 31329