ATTACHMENT 1

Lincoln Trail District Health Department

P.O. Box 2609
108 New Glendale Road
Elizabethtown, KY 42702
(P) 270-769-1601, (F) 270-765-7274

Special Needs Registry
Registration Form
(PLEASE PRINT)

_____ _____ _____
Last First Middle Initial

_____ _____ _____ _____ _____ _____
Address Apt. # County City State Zip

(_____) _____
Phone/TTY Email

Gender: ☐ Male ☐ Female Date of Birth ____/____/____ Weight _____

Number of relatives living with you who will accompany you to a shelter if need be: _____

Emergency Contact Information
Name _____ Phone Number (_____) _____
Address _____ City _____ State _____ Zip _____

Residence Type: ☐ Private Home ☐ Apartment/Condo ☐ Mobile Home ☐ High-Rise ☐ Group Home
☐ Assisted Living ☐ Duplex ☐ Dorm ☐ Other _____

Name of complex/subdivision: _____
Year-round resident? ☐ YES ☐ NO If no, from _____ to _____

Do you have pets? ☐ YES ☐ NO If yes, what type and how many _____
Do you have arrangements for them in an emergency? ☐ YES ☐ NO
(Please be advised that pets may NOT accompany you to a shelter unless they are companion/service animals)

Evacuation Information
Will you require evacuation assistance? ☐ YES ☐ NO
Do you: ☐ Care for yourself **OR** ☐ Regularly have assistance from a caregiver
Name of caregiver _____ Phone Number (_____) _____
Address _____ City _____ State _____ Zip _____

Transportation (Check all that apply)
☐ I will provide my own transportation ☐ I can get to a bus pickup point ☐ I need a wheelchair lift equipped vehicle
☐ I am ambulatory with no assistance ☐ I am ambulatory with assistance
☐ I am bedridden and require stretcher transport ☐ I can transfer from a wheelchair to a seat

Special Equipment (Check all that apply)
☐ Wheelchair dependent
☐ Walker/Cane
☐ Medical Equipment Requiring Electricity, type _____
☐ Oxygen Dependent
☐ Other (please describe) _____

Type of Disability/Special Need (check all that apply)
☐ Deaf/Hearing Impaired If yes, ☐ Require an Interpreter
☐ Blind/Visually Impaired ☐ I have hearing/seeing service animal which will accompany me
☐ Mental Disability ☐ Bedridden ☐ Alzheimer's ☐ Developmental Disability ☐ None
☐ Other: _____

Is Your Disability/Special Need: ☐ Temporary **OR** ☐ Permanent
If temporary, please give a medical release date _____
NOTE: unless you notify registry personnel, you will be deleted from registry as of the above date.

What illness do you take medication for : (check all that apply)

ILLNESS	MEDICATION(S) TAKEN
☐ Heart problems	_____
☐ Blood pressure	_____
☐ Stroke	_____
☐ Diabetes	_____
☐ Breathing problems. Type _____	_____
☐ Back problems	_____
☐ Seizures/convulsions	_____
☐ Contagious disease, Type _____	_____
☐ Behavioral Health	_____
☐ Arthritis / Osteoporosis	_____
☐ Cancer, Type _____	_____

☐ Dialysis, number of times per week _____
☐ Other _____

☐ Allergies to any medicines, list _____

Do you require a special diet? ☐ YES ☐ NO If yes, what type? _____

Name of Family/Primary Care Physician: _____ Phone Number (_____) _____

Do you have any other comments or suggestions that may assist us in your care during an emergency/disaster? _____
_____
_____

Completing this registration form DOES NOT create a contract for services. Neither the entities or individuals that have created or maintained this registry or collected information for this registry, nor any entity or individual that may utilize the information contained in the registry including but not limited to Lincoln Trail District Health Department, Commonwealth of Kentucky, its Cabinets, Departments, or Associations, emergency personnel and volunteers, warrant that assistance will be provided to you during an emergency or disaster.

Participation in this registry is voluntary. It is your duty and responsibility to update your information on this registry. By completing this registration form you hereby confirm and attest that the information provided in this registration is correct and that should the information that you have provided change, you will promptly update the registry. By completing this registration form, you also hereby warrant that the information you have provided has been provided voluntarily and that if you have required assistance to complete this form that you have consented to the assistance provided. By completing this registration form you also hereby waive any and all claims which relate to the collection, maintenance or use of the information you have supplied which may be asserted against the entities or individuals that have created or maintained this registry or collected information for this registry and any entity or individual that may utilize the information contained in the registry including but not limited to Lincoln Trail District Health Department, Commonwealth of Kentucky, its Cabinets, Departments, or Associations, emergency personnel and volunteers.

Registrant's Signature: _____ Date: _____
If caregiver provided information or completed registration form on behalf of registrant –
Caregiver Name: _____
Caregiver's Signature: _____ Date: _____
Relationship to Registrant (if any) _____

Please mail form back to: Lincoln Trail District Health Department
MRC Coordinator
P.O. Box 2609
Elizabethtown, KY 42702

LEXINGTON FAYETTE COUNTY SPECIAL NEEDS REGISTRY FORM

Submit by Email

Type information in the fields below. Click the 'Submit by Email' button.
Print and sign the form, then mail (see mailing instructions at end of form).

Print Form | Reset Form

Date ☐ New Application ☐ Update of Previous Application

PERSONAL INFORMATION

First Name | Last Name | Mid Initial | Date of Birth | ☐ M ☐ F

Street Address | City Lexington | Zip

If temporary address, give dates: From | To | Flood Prone Area ☐ Yes ☐ No

Mailing Address | City Lexington | Zip

Home # | Cell # | Work/Alt # | Phone/TTY #

Residence: ☐ Single Family ☐ Multi-Story ☐ Long Term Care ☐ Mobile Home

Living Situation: ☐ Alone ☐ With Spouse ☐ With Caregiver Caregiver name/relationship:

# of Dependents less than 18 years old: # of Dependents 18 years and older:

Primary Language | Require a translator ☐ Yes ☐ No If so, what language

Email Address | Alternate Email Address

Pets: # Dog(s) | # Cat(s) | Service Animal (Type) | Other (Type)

MEDICAL INFORMATION

Condition/Disability

If temporary condition, give dates From To

Medications (prescription, over-the-counter, and herbal):

	Medication Name	Dosage	How Often	Needs Refrigeration
1.				☐
2.				☐
3.				☐
4.				☐
5.				☐
6.				☐
7.				☐
8.				☐
9.				☐
10.				☐

Medication Name	Dose	How Often	Needs Refrigeration
11.			☐
12.			☐
13.			☐
14.			☐
15.			☐
16.			☐
17.			☐
18.			☐
19.			☐
20.			☐

If you need to list more medications, record the information on an separate piece of paper.

Home Health Agency	Medical Equipment Supply Co.	Dialysis Center

Other Agency Affiliations (i.e., Hearing, Visual, Developmental, Mental Health Services, Other Special Services)

Dialysis: ☐ Home ☐ Center Times dialyzed per week

OXYGEN REQUIREMENTS:

☐ Concentrator ☐ Respirator (Ventilator) ☐ Portable ☐ Suction Machine ☐ Nebulizer ☐ Other

Oxygen Frequency: ☐ Continuous ☐ Treatments Only ☐ PRN (As Needed)

Nighttime # Hrs Daytime # Hrs Amt used in 24 hrs How often

ADDITIONAL MEDICAL INFORMATION:

Height Weight **Paralysis:** ☐ Complete ☐ Partial

Pregnant ☐ Due Date High Risk? ☐ Explain

☐ Open wounds that require dressing changes How often

☐ Sight Impaired ☐ Glasses ☐ Contacts ☐ Hearing Impaired ☐ Hearing Aid

☐ Memory Impaired ☐ Mobility Impaired ☐ Speech Impaired ☐ Dentures ☐ Diabetes

☐ High Blood Pressure ☐ Severe Arthritis ☐ Anxiety/Depression ☐ Heart Condition ☐ Cardiac History

☐ Life-sustaining Medications ☐ Frail ☐ Wheelchair Bound ☐ Bedridden ☐ Incontinent

☐ Emergency Alert Equipment ☐ DNR Order (if so, attach copy) ☐ Required or Life-Sustaining Med Equip.

☐ Mental Health Impaired (Explain)

☐ Special Dietary Needs (Explain)

☐ Contagious/Infectious Disease (Explain)

☐ Other Issues (Explain)

Allergies (Medical and Non-Medical

EMERGENCY CONTACT INFORMATION

First Name | Last Name | Relationship | Phone:

First Name | Last Name | Relationship | Phone:

PHYSICIAN/PHARMACY INFORMATION

Primary Care Provider | Provider Phone:

Pharmacy Name | Pharmacy Phone:

TRANSPORTATION INFORMATION

Do you need assistance to evacuate your dwelling in an emergency? ☐ Yes ☐ No

Can you provide your own transportation to a shelter? ☐ Yes ☐ No

If you will need transportation assistance, check the type you will need:

☐ Automobile ☐ Van with wheelchair lift ☐ Stretcher ☐ Ambulance (patient must initial) **

** (Note: if ambulance is requested, patient will be responsible for transportation costs of ambulance.)

APPLICANT REPRESENTATIVE

If the person completing this form is not the applicant, please answer the following:

Name | Relationship/Agency

Applicant has been notified of this registration? ☐ Yes ☐ No

Sign _____ Date _____

PRIVACY STATEMENT

We respect your right to confidentiality and continuously take every possible measure to ensure that your personal information remains confidential. We do not collect or maintain information about you that is not essential for your safety and well-being.

All employees of the Lexington-Fayette County Health Department and the Lexington Fayette Urban County Government Division of Environmental and Emergency Management are required to adhere to this privacy statement of confidentiality and nondisclosure.

AUTHORIZATION INFORMATION

I authorize emergency response personnel to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare. I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

I hereby provide my consent for the members of the Lexington-Fayette County Health Department and the Lexington Fayette Urban County Government Division of Environmental and Emergency Management to have access to the medical information contained in this form. I further understand that only those persons who have a 'need to know this information' will have access to it. This release remains in effect until further notice unless revoked by me in writing.

I agree that my name be added to the Special Needs Emergency Shelter Registry. I understand that this form is not a reservation for the Special Needs Shelter, but that my medical information will be used to determine/assess plans appropriate for my care and treatment during an emergency.

I understand that the Special Needs Shelter may not be air conditioned if emergency power is required. I understand that I need to bring with me all medications, in marked bottles, and all medical supplies I use for my care for up to 7 days (one week).

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Division of Environmental and Emergency Management will determine which emergency evacuation assistance, if any, this program may be able to provide.

Sign _____ Date _____

☐ Check if you are an organ donor

Please sign and mail to:
DEEM, 166 N Martin Luther King Blvd, Lexington, KY 40507
or fax to 859-252-8689.

Created: June 2007
Edit: April 3, 2008

SPECIAL NEEDS REGISTRY INFORMATION

If you or other members of your household would require special assistance in the event of an emergency evacuation, please complete this form or call 2-1-1 to register over the phone, so that special arrangements can be made in advance. This information will be kept confidential and will be forwarded to state and local emergency responders in Woodbury County.

NAME_____ D.O.B__/__/__
PHONE:_____ ADDRESS_____
_____LOT#_____ APT #_____
CITY_____STATE_____ZIP_____
TYPE OF DWELLING: APARTMENT COMPLEX CONDO DUPLEX
PRIVATE HOME GROUP HOME
NUMBER OF RESIDENTS IN HOME_____
LANGUAGE SPOKEN IN THE HOME_____
FULL – TIME RESIDENT (yes ___ no ___)
PART – TIME RESIDENT / WHICH MONTHS LIVING AT THIS RESIDENCE _____

EMERGENCY CONTACT (<u>NOT LIVING WITH YOU</u>):
_____PHONE_____
ADDRESS_____
CITY_____STATE_____ZIP_____
RELATIONSHIP_____

OUT OF CITY CONTACT_____ PHONE _____
ADDRESS_____
CITY_____STATE_____ZIP_____

IF YOU GO TO A SHELTER, WHO WILL BE STAYING WITH YOU?
_____PHONE_____

PHYSICIAN NAME_____PHONE_____
HOME HEALTH AGENCY_____PHONE_____

SUBSCRIBE TO LIFELINE OR OTHER EMERGENCY NOTIFICATION SYSTEMS:
YES NO

CITIZEN MOBILITY

_____Can walk _____ needs assistance
_____Wheel Chair If so, do you have your own? Y N
_____Bedridden If so, can you be moved by wheelchair? Y N

TRANSPORTATION INFORMATION

If, in an emergency situation, you were instructed to leave your home and move to an emergency shelter, how would you get there?
_____Your own car _____Neighbor _____Do not have a way

TRANSPORTATION NEEDS

_____Ambulance _____Van with wheelchair lift _____Walker Assistance
_____Regular car or van _____Other _____

MEDICAL INFORMATION:
Please check all disabilities that you have

_____Hearing impaired TTD? Y N
_____Blind Guide Dog? Y N
_____Do you use electrically dependent life support systems?
_____Oxygen Supported? L/min _____ Tank_____ O2 Converter_____
_____Does anyone in this home have any special issues that may prevent them from leaving the home during an emergency or stressful situation? YES NO
Please explain: _____

_____

PET INFORMATION

Do you have a pet? Y N
If so, what kind? Dog Cat
Other_____
Is this a service animal? Y N
Have you made arrangements for sheltering your pet? Y N
What are the arrangements? _____

RELEASE OF INFORMATION

I,_____, GIVE MY AUTHORIZATION FOR THE MEDICAL INFORMATION CONTAINED HEREIN TO BE RELEASED TO THE EMERGENCY SERVICES PERSONNEL AND SIOUXLAND DISTRICT HEALTH DEPARTMENT. I UNDERSTAND THAT THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING MY NEEDS IN A TIME OF AN EMERGENCY AND WILL BE MAINTAINED AS CONFIDENTIAL. I PROVIDE THIS INFORMATION ON A VOLUNTEER BASIS.

SIGNATURE:_____DATE: ___/___/___

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____

WITNESS_____DATE___/___/___

OFFICE USE ONLY

Date Survey Completed: _____ Incident #_____

	Date	District #	Map Reference	Initial
CAD:	_____	_____	_____	_____
RTE	_____	_____	_____	_____