Coastal Health District Hurricane Registry Application

Note: Please PRINT the entire form and mail it or hand-deliver it to your county health department. Mailing and physical addresses are on the final page of the application. 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 medical support 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 medical support shelter.
- Shelters will provide limited space, with possibly only 1-2 feet of walkaround space between individual areas.
- 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.
- Only registered service animals will be allowed at the medical support shelter.
- The medical support shelter is housed on a campus with ongoing public safety trainings and exercises. You can expect to hear noises associated with those trainings and exercises. (Examples include but are not limited to early morning workouts, road noises like screeching tires and brakes, sirens, and gunfire).

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Section 1 — Required Personal Enrollment Data (One Person Per Form)

Date of Application: _____ ☐ **New Application** ☐ **Update of existing application**

Name:

Last: _____ First: _____ Middle: _____

Date of Birth: _____ **Gender:** _____ **Race/Ethnicity**: _____

Tracking Number (for official use only): _____

Street address:

_____

Street City State Zip Apt/Room# County

Mailing address (if different from above):

_____

Street City State Zip Apr/Room# County

Phone: _____ **Cell phone**: _____ **Alternate Phone:** _____

☐ Client Hearing Impaired, Telecommunication Service Required
☐ Client Visually Impaired, Assistive Service Required

Weight: _____ lbs. **Height**: _____ ft. _____ in.

Primary language: _____ **Level of English Proficiency:** _____

Housing:

***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

Living situation:

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

☐ Living with spouse ☐ Living with Other (specify) _____

Name of contact(s) in home: _____ Phone: _____

Name of Spouse: (If Applicable) _____ Is Spouse Registered? _____

Person completing this form: ☐ Self ☐ Other (Name): _____

Person's phone #: _____

Section 2 Emergency Contacts

Name: _____ Relationship: _____ Phone: _____

Cell Phone: _____

Name: _____ Relationship: _____ Phone: _____

Cell Phone: _____

Name: _____ Relationship: _____ Phone: _____

Cell Phone: _____

Section 3 Functional and Medical Needs

What transportation accommodations do you require, if any, when traveling for physician appointments?

Check all that apply:

☐ Wheelchair accessible vehicle ☐ Ambulance ☐ Assistance while entering/exiting vehicle

☐ Transportation of required equipment ☐ Other: _____

Mobility Level/Status:

How do you transfer from bed to chair? _____

How do you transfer from a wheelchair? _____

Do you need assistance with toileting? _____

Sustainable Life Equipment:

Medical dependence on electricity? ☐ Yes ☐ No

If yes, check all that apply:

☐ Oxygen concentrator ☐ Nebulizer ☐ Feeding pump ☐ Suction

☐ Additional Medical Devices: (specify) _____

Additional Special Needs - Check all that apply:

☐ Oxygen Company ☐ Chronic Respiratory Condition ☐ Assistance with Administration of Medications

☐ Walker ☐ Cane ☐ Help Climbing Stairs ☐ Wheelchair ☐ Can Transfer to/from Wheelchair

☐ Cognitive Impairment ☐ Anxiety/Depression ☐ Mental Health Problem ☐ Alzheimer's/Dementia

☐ Open Wounds/Decubitus ☐ Respirator/Ventilator Dependent ☐ Bedridden ☐ Speech Impairment

☐ Vision Loss/Impaired ☐ Hearing Loss/Impaired ☐ Incontinence ☐ Service Animal

☐ Dialysis Dependent ☐ Insulin Dependent Diabetes ☐ Morbid Obesity ☐ Hypertension

☐ Immune deficiency ☐ Meds Require Refrigeration ☐ Needs Some Assistance with ADLs

☐ Daily Assistance from Caregiver ☐ Allergies to Foods ☐ Dietary Restrictions

☐ Communication Aids/Services ☐ Other_____

Other Considerations:

Dialysis Provider: _____

Dialysis Provider Phone #: _____

Dialysis Schedule: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Cognitive Impairment (specify) _____

Mental Health Problem (specify): _____

Open Wounds/Decubitus (specify): _____

Speech Impairment (specify): _____

Vision Loss/Impairment (specify): _____

Meds Require Refrigeration (specify): _____

Needs Some Assistance (specify): _____

Other (specify): _____

Dietary Restrictions (specify): _____

Care Requirements: ☐ Oxygen Required ☐ Durable Medical Equipment (DME)

☐ Consumable medical supplies (CMS) ☐ Personal Assistance Service (PAS)

Oxygen Provider (company name): _____

Required Flow Rate L/M: _____ Phone: _____

Durable Medical Equipment (DME):

Provider Name: _____ Phone: _____

Consumable medical supplies (CMS):

Provider Name: _____ Phone: _____

Personal Assistance (PAS):

Provider Name: _____ Phone: _____

Sleeping accommodations:

☐ Accessible cot ☐ Crib ☐ Other: _____

Access to Transportation:

☐ Wheelchair Accessible Vehicle

☐ Individualized Assistance

☐ Transportation of Equipment Required

Do you need assistance with the following activities? Please check all that apply.

☐ Eating ☐ Taking medication ☐ Transferring to/from Wheelchair or Other Mobility Aid

☐ Dressing/undressing ☐ Walking ☐ Bathing ☐ Toileting ☐ Communicating

Underlying Health Conditions:

_____

_____

_____

Check all that apply: ☐ IV medication ☐ Dependent on Power Operating Equipment to Sustain Life

☐ Medical Diagnosis: _____

Requires licensed care provider to perform the following: _____

_____

☐ Terminal: _____

☐ Contagious conditions (specify): _____

☐ Ongoing treatment: (Please add information on any of the previous conditions)

_____

☐ Other: _____

_____

_____

Section 4 Caregiver Information

A caregiver **SHOULD** travel with registrant.

Do you have a caregiver? ☐ Yes ☐ No

Caregiver name: _____ Phone: _____

What type of transportation do you need? ☐ Bus ☐ Wheelchair van ☐ Ambulance

Service Animal:

Do you have a service animal? ☐ Yes ☐ No Approximate weight of animal: _____ pounds

Type of service animal: ☐ Dog/K9 Dog Breed: _____ ☐ Miniature Horse/Pony

Do you have a carrier for your pet? ☐ Yes ☐ No

Do you have proof of pet's vaccination status? ☐ Yes ☐ No

Section 5 Provider and Insurance Information

Primary Care provider/doctor:

Provider Name: _____ Phone: _____

Home Health Agency:

Provider Name: _____ Phone: _____

Other Health Service Provider:

Provider Name: _____ Phone: _____

Pharmacy:

Provider Name: _____ Phone: _____

Medicaid: _____

Medicaid ID: _____

Medicare: _____

Medicare ID: _____

Health Insurance Company: _____ Phone: _____

Insurance Policy #: _____ Insurance Group #: _____

Case Manager (name and organization): _____

Case Manager Email: _____ Phone: _____

Other medical condition(s):

_____

_____

_____

Allergies (i.e., medical, dietary, environmental, industrial, animal):

_____

_____

Please list your current medication(s):

_____

_____

_____

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): _____

Address/Company: _____ Phone: _____

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Please mail or hand-deliver completed application to:

Bryan County

Mailing Address:	**Physical Address:**
Bryan County Health Dept., Attn: Barbara Bilbrey P.O. Box 9, Pembroke, GA 31321	430 Ledford Street in Pembroke, **or** 66 Captain Matthew Freeman Drive in Richmond Hill

Camden County

Mailing Address:	**Physical Address:**
Camden County Health Dept., Attn: Melissa Perkins 101 Winding Rd., Kingsland, GA 31548	101 Winding Road Kingsland, GA 31548

Chatham County

Mailing Address:	**Physical Address:**
Chatham County Health Dept., Attn: Sierra Peebles 1395 Eisenhower Dr., Savannah, GA 31406	1395 Eisenhower Dr. Savannah, GA 31406

Effingham County

Mailing Address:	**Physical Address:**
Effingham Co. Health Dept., Attn: Bethany Thornton P.O. Box 350, Springfield, GA 31329	802 Hwy 119 South Springfield, GA 31329

Glynn County

Mailing Address:	**Physical Address:**
Glynn Co. Health Dept., Attn: Adam Sanchez 2747 Fourth St., Brunswick, GA 31520	2747 Fourth St. Brunswick, GA 31520

Liberty County

Mailing Address:	**Physical Address:**
Liberty Co. Health Dept., Attn: Jennifer Mele P.O. Box 231, Hinesville, GA 31310	1113 East Oglethorpe Hwy. Hinesville, GA 31313

Long County

Mailing Address:	**Physical Address:**
Long County Health Dept., Attn: Lisa Palmer P.O. Box 279, Ludowici, GA 31316	584 N. Macon St. Ludowici, GA 31316

McIntosh County

Mailing Address:	**Physical Address:**
McIntosh Co. Health Dept., Attn: Brooke Deverger P.O. Box 231, Townsend, GA 31331	1335 Ga Hwy 57, Townsend, GA 31331