Suffolk County Special Needs Registry Application

First Name | Middle Initial | Last Name

Apt-Lot number | What Floor? | Address

Township-Halmet | State | Zip Code

Year Round ◯ Yes ◯ No | Nearest Cross St.

Mailing Address if Different | Township-Hamlet

State | Zip Code | Home Phone | ☐ TDD/TTY Device

Cell Phone | ☐ TDD/TYY Device

E-mail Address

Primary Language ◯ English ◯ Spanish | Primary Language Other

Gender | Height Ft. | Height Inches | Weight | DOB

If Married Spouse's Name | If Married is your Spouse Registered? ◯ Yes ◯ No

Spouse's Cell Phone | Spouse's E-mail Address

Type of Residence ◯ Single Family ◯ Apartment ◯ Mobile Home ◯ Home-Duplex ◯ Condo ◯ Other

Other Type of Residence

Number of Cats in Home | Number of Dogs in Home | Other Type of Pet

Number of Other Type Pets | Service Animal

Pets cannot be accommodated at special needs shelters; so please be sure to make arrangements, in the event you need to evacuate your residence, for your pets to stay with a relative, friend or at a commercial boarding location.

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In case of an emergency evacuation, where do you plan to go?

◯ I have made arrangement to stay with relatives, friends, a community organization, or hotel in a non-evacuation area.

◯ I am unable to make other arrangements and must go to an evacuation center.

Do you need transport to a shelter? ◯ Yes ◯ No

Do you need a wheelchair lift? ◯ Yes ◯ No

Do you require a stretcher? ◯ Yes ◯ No

Do you require any additional Mobility Aids? _____

Are you receiving Home Health Care? ◯ Yes ◯ No

If Yes Name of Agency _____

If you have a caregiver, please list their name and phone number.

Name of Care Giver _____ Care Giver Phone _____

You are entitled to have one person accompanying you to the shelter

◯ One person will accompany me to the shelter

◯ I will be unaccompanied when I go to the shelter

Check all that apply about your conditions

☐ Alzheimer's -Note Stage- _____

☐ Amyotrophic lateral sclerosis (ALS)

☐ Back Injury

☐ Blind, Hearing or Speech Impaired

☐ Cerebral Palsy

☐ Colostomy or Ileostomy -Specify- _____

☐ Contagious Disease -Specify- _____

☐ Epilepsy or Other Seizures - Specify _____

☐ Incontinence

☐ Fractured Bones with Pin Care

☐ Full Paralysis

☐ Heart Conditions

☐ High Blood Pressure

☐ Cognitive Disability

Check all that apply about your conditions

☐ Mental Illness -Specify-

☐ Special Diet -Specify-

☐ Pregnant in 7th month or more.

☐ Severe Arthritis

☐ Other Condition -Specify-

Are you dependant on any of the following?

☐ Ambulatory with assistance

☐ Non - Ambulatory (bedridden)

☐ Walker/ Cane/ Crutches

☐ Wheelchair on occasion

☐ Wheelchair Bound

☐ Catheters

☐ NG tube/CV infusion site/tracheostomy

☐ Insulin

☐ IV Medication

☐ Oxygen Dependent

☐ Respirator

☐ Oxygen Intermittent

☐ CPAP, BiPAP

☐ Dialysis HEMO ☐ Dialysis Peritoneal

Dialysis - no dialysis will be available at the shelter

☐ I am dependent on electricity to live.

☐ Pregnant in 7th month or more

If so, briefly explain

List all of your medications:

Name of Medication Dosage

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Name of Medication _____ Dosage _____

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Name of Medication _____ Dosage _____

Allergies _____

You must give name & phone number of a neighbor or friend that we may use for an alternate contact. This person must live in your area & must be aware that they are listed as an alternate contact

Emergency Contacts

Name _____

Address _____

Township/ Hamlet _____ State _____

Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Additional Contact

Name _____

Address _____

Township/ Hamlet _____ State _____

Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Additional Contact

Name _____

Address _____

Township/ Hamlet _____ State _____

Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Additional Contact

Name

Address

Township/ Hamlet State

Zip Home Phone Work Phone

Cell Phone E-Mail Address

◯ I authorize ◯ I do not authorize emergency personnel to enter my home during search and rescue personnel to enter my home during search and rescue operations if necessary to assure my safety and welfare following a disaster.

Comments that are Important

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet attached and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I also grant permission to emergency personnel to enter my home following an emergency if deemed necessary by proper authorities. I understand that this registration is voluntary and hereby request registration in the Special Needs Program. I understand that all information given will be held in strict confidence and will be used for emergencies only.

☐ I Agree