Special Needs Registry Form

Name:_____
Physical Address:_____
Mailing Address:_____
Phone Number:_____
Date of Birth:_____ Age:_____
Weight: _____
Physician's Name:_____
Phone:_____
Home Health Care Provider:_____
Phone:_____
Where do you plan to stay during an evacuation?
_____home Will you be alone? _yes _____no

_____with friends/family

_____emergency shelter
Can you get to an evacuation shelter? _____yes ___no
If no, check(**one**) for the appropriate transportation needed:
_____standard vehicle (car, van)
_____wheelchair equipped
_____ambulance
_____bariatric medical transport
Do you have a caregiver?
_____yes _____no
Caregiver's name and phone number who will be accompanying you at the shelter? _____
_____

***If you do require a caregiver, your caregiver MUST accompany you to the facility as assistance is NOT provided by the facility. Have you made arrangements for pets as they are not allowed in evacuation shelters?*_____

***Please check all special needs you may have*:**
_____ legally blind
_____ deaf
_____ terminally ill
_____ contagious disease
_____ bedridden
_____ ambulatory with assistance (walker, cane, wheelchair, etc.)
_____ dialysis (3 or more times per week)
_____ IV fluids or medication
_____ insulin dependent (need assistance)
_____ feeding tube
_____ catheter (other than urinary)
_____ severe respiratory illness
_____ oxygen tank number of hours/day_____
do you have a portable tank ___yes ___no
_____ severe mental handicap
_____ severe mental illness
_____ end-stage Alzheimer's
_____ chronic incontinence
_____ advanced senile dementia
_____ require complex dressing changes
_____ unstable Gran Mal seizures
_____ moderate to severe symptomatic HIV/AIDS
_____ medically dependent on electricity
equipment: _____
_____ access to a generator
_____ type of diet _____
*Additional Information*_____
_____

COVID-19 SCREENING
1. Have you or anyone in your household been tested for COVID-19? Yes____ No____
2. Have you received the COVID-19 vaccine? Yes___ No_____
3. Have you or anyone in your household had the following symptoms in the last 21 days: sore throat, fever, cough, chills, shortness of breath, loss of smell or taste, fever at or greater than 100 degrees Fahrenheit? Yes____ No____
4. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19? Yes____ No____

_____

Emergency Contact
Name:_____
Relationship:_____
Phone (day)_____ (night)_____

Please submit completed form to:

I certify that the above information is correct to the best of my knowledge. Services provided during the specified disaster will be provided at no charge. If you continue to utilize services after you have been cleared to return home, you will be responsible for those costs.
Signed_____ **Date**_____

Attn: Special Needs Registry
Craven Co DSS
P.O. Box 12039
New Bern, NC 28561-2039
Or email:
cravencounty.dss@cravencountync.gov

Applicants will be screened by a member of Craven County Department of Social Services to ensure those with special needs receive care in the appropriate facility during an emergency. Those who are found to have special needs that an American Red Cross shelter cannot provide will be contacted for further screening.

All information provided on this form is voluntary and confidential; however, it may be shared with but not limited to emergency personnel, transportation services, and licensed facilities etc. to facilitate your quick and safe evacuation.

Due to the time required and limited resources to safely evacuate people with special needs, the evacuation process may be executed well in advance of an impending disaster. *You must be ready to evacuate when told to do so by emergency officials!!*

If you have questions or need assistance filling out the form, please contact Craven County DSS Adult Services at 252-636-4900.

Special Needs Registry Form

Do you need special medical care during a disaster?
Do you need help to evacuate?

Craven County

1712

If so, you should fill out this form to get the help you need during a disaster.
Year: 2021