

# 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 \_\_\_\_\_

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## **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\_\_\_\_\_

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## **Emergency Contact**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone (day) \_\_\_\_\_ (night) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

**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**



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

*Year: 2022*