Durham City/County Emergency Management

ACCESS AND FUNCTIONAL NEEDS REGISTRY FORM 2018

Please Note: Residents are encouraged to make arrangements with a health agency, friends, or family for shelter needs during an emergency. The County shelter is considered a *shelter of last resort*.

(Please print or type the information and complete all pages. A new registration form should be completed annually.)

PERSONAL INFORMATION FOR INDIVIDUAL WITH NEED

Name: ____
(First Name, Mi, Last Name)

Physical Address: ____

City: ____________________ State: ________ Zip Code: ____________________

Residence Type: ☐ Single Family Home ☐ Multi-Family Home ☐ Mobile Home ☐ Apartment ☐ Homeless

Mailing Address: ____
(Please enter if different than your Physical Address)

City: ____________________ State: ________ Zip Code: ____________________

Email: ____

Primary Phone: (________) _________ - ________________ Primary Phone TTY/TTD ☐ Prefer Text ☐

Secondary Phone: (________) _________ - ________________ ☐ I do not have a phone

Date of Birth (MM/DD/YYYY) _____/______/____________ Height: ____________

Gender: ____________ Eye Color: _____________ Weight: __________

PERSONAL INFORMATION FOR EMERGENCY CONTACT

Local Emergency Contact Name: ____
(First Name, Mi, Last Name)

Address: ______________________________ City: ____________________ State: ______

Relationship: ☐ Other ☐ Friend ☐ Family ☐ Neighbor ☐ Caregiver Zip Code: ____________________

Email: ____

Primary Phone: (______) ______________________ Secondary Phone: (______) ______________________

Secondary/Out of Area Emergency Contact Name: ____
(First Name, Mi, Last Name)

Address: ______________________________ City: ____________________ State: ______

Relationship: ☐ Other ☐ Friend ☐ Family ☐ Neighbor ☐ Caregiver Zip Code: ____________________

Email: ____

Primary Phone: (______) ______________________ Secondary Phone: (______) ______________________

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Additional Contact Information

Physician Information

Name: ______________________________ Phone: (______) ____________________

Caregiver Information

Name: ______________________________ Phone: (______) ____________________

Home Health Care Information

Name: ______________________________ Phone: (______) ____________________

Pharmacy Information

Name: ______________________________ Phone: (______) ____________________

Evacuation Assistance Information

- ☐ Blind/Low Vision
- ☐ Deaf/Hard of Hearing
- ☐ Behavioral Health Issues
- ☐ Contagious Disease
- ☐ Frail/Elderly
- ☐ Speech Impediment
- ☐ Physical Disability
- ☐ Bedridden
- ☐ Mentally/Memory Impaired
- ☐ Hemodialysis at Facility
- ☐ Hemodialysis at Home
- ☐ Peritoneal Dialysis
- ☐ Constant Skilled Nursing Care
- ☐ Home Hospice
- ☐ Power Dependent Device
- ☐ Assistance with Medications
- ☐ Assistance with Insulin
- ☐ Requires Refrigerated Meds
- ☐ Autism
- ☐ Dietary Needs/Restrictions
- ☐ Seizures

Dementia/Alzheimer's

- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Other

____

Communication Limitations

- ☐ No Radio
- ☐ No Television
- ☐ No Telephone, TTY, or VRI
- ☐ No Access to Internet
- ☐ Does Not Speak English
- ☐ Language:

____

Transportation Needs

- ☐ Car
- ☐ Bus
- ☐ Wheelchair Van
- ☐ Ambulance

Has Difficulty Walking and Requires

- ☐ Walker / Cane
- ☐ Standard Wheelchair
- ☐ Motorized Scooter
- ☐ Attendant to Assist in Walking
- ☐ Requires Stretcher Transportation
- ☐ Hoyer Lift

Oxygen Dependent

- ☐ 24 Hour
- ☐ Only Overnight
- ☐ Nebulizer
- ☐ CPAP
- ☐ Other

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____
____

Medical Equipment Not Easily Transportable

- ☐ Ventilator
- ☐ Suction Machine
- ☐ Catheters
- ☐ Feeding Tube
- ☐ Oxygen Concentrator
- ☐ Other Equipment

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Required Assistance

1. Are ALL of the support needs resulting in the need for evacuation assistance temporary? (Example: The individual is bedridden due to pregnancy difficulties, but is expected to be fully recovered after the baby is delivered.)
   ☐ Yes ☐ No, the condition(s) are expected to be permanent.
2. Is the person in need a seasonal resident? ☐ Yes ☐ No From: ___________ to ____________
3. Does the person in need require evacuation assistance 24 hours/day? ☐ Yes ☐ No
4. Does the person in need have a 24 hour caregiver? ☐ Yes ☐ No
   a. Will the caregiver travel and/or stay with you? ☐ Yes ☐ No
   Durham County requires you bring a caregiver with you to the Shelter

Medication List

In lieu of filling out this section of the registration, you may attach a copy of your medication list from your Doctor or Pharmacy. If using this form, please list medication information below.

Medication Name	Dosage	Frequency

Service Animals

Name: ________________________________ Type: ☐ Dog ☐ Miniature Horse

Pets/Comfort Animals/Emotional Support Animals

Name: ________________________________ Type: ☐ Dog ☐ Cat ☐ Other ________________________

Name: ________________________________ Type: ☐ Dog ☐ Cat ☐ Other ________________________

Name: ________________________________ Type: ☐ Dog ☐ Cat ☐ Other ________________________

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IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING

I understand:

- Registration is voluntary and hereby request registration in the "Access and Functional Needs Program".
- Emergency shelters may be made available to provide protection during a period of immediate danger.
- I am required to bring a caregiver while at the shelter if I cannot manage my own needs.
- I have a copy of the Access and Functional Needs Program Guidelines and will take the things that I need with me to the shelter should I choose to go.
- I will ensure that a pet carrier or crate and necessary items is available for my pet being taken to or going to the pet shelter.
- Limited volunteer nursing, medical assistance, supplies, and equipment shelter may be available to assist me and/or my caregiver.
- I understand that I will need to make alternative arrangements in the event that I am unable to return to my home after an event.
- I will be responsible for any charges and costs associated with hospitalization or other medical facilities including care and medical transportation, if they should become necessary.

Transportation:

- I may be asked to evacuate my residence. All reasonable attempts will be made to give advance notice. Monitor Government TV (DTV Channel 8), Local TV stations, or Local Radio Stations for updated information. If I decline transportation when the transporter arrives, I will be required to sign a "Refusal Form". I understand that upon declining transportation, I will not have another opportunity to request this service.

I agree:

- To opt-in to receive Durham City/County Emergency Management's automated telephone notifications and/or texts prior to and after an emergency. This will include occasional tests to make sure our system is up to date and functional.
- By signing this form, I give my authorization for medical information contained herein to be released to the North Carolina Department of Health, State and County emergency management agencies, and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt from the provisions of G.S 132-1, Public Records Law under NCGS 166A-19.15(f)(5). The information contained here will be kept confidential.
- The information contained herein is true and correct to the best of my knowledge. I have read and understand the information on this form as well as the attached Guidelines document.
- By signing, I grant permission to health care providers, transportation agencies, and responders as necessary to provide care, and to disclose any information that is necessary to respond to my needs.

Signature of Registrant/Authorized Caregiver/Person Completing the Form ____________ Date ____________

Please complete and return form to:

Durham City/County Emergency Management
2422 Broad St
Durham, NC 27704

Or scan and email:

EMPlans@dconc.gov