



**EMERGENCY
MANAGEMENT
DIVISION**

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: _____ Zip Code: _____

Relationship: Friend Family Neighbor Caregiver Other

Email: _____

Primary Phone: (_____) _____

Secondary Phone: (_____) _____

Secondary/Out of Area Emergency Contact Name:

(First Name, Mi, Last Name)

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: Friend Family Neighbor Caregiver Other

Email: _____

Primary Phone: (_____) _____

Secondary Phone: (_____) _____

Additional Contact Information

Physician Information

Name: _____

Phone: (_____) _____

Caregiver Information

Name: _____

Phone: (_____) _____

Home Health Care Information

Name: _____

Phone: (_____) _____

Pharmacy Information

Name: _____

Phone: (_____) _____

Evacuation Assistance Information

- | | |
|---|--|
| <input type="checkbox"/> Blind/Low Vision | <input type="checkbox"/> Mentally/Memory Impaired |
| <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Hemodialysis at Facility |
| <input type="checkbox"/> Behavioral Health Issues | <input type="checkbox"/> Hemodialysis at Home |
| <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Peritoneal Dialysis |
| <input type="checkbox"/> Frail/Elderly | <input type="checkbox"/> Constant Skilled Nursing Care |
| <input type="checkbox"/> Speech Impediment | <input type="checkbox"/> Home Hospice |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Power Dependent Device |
| <input type="checkbox"/> Bedridden | <input type="checkbox"/> Assistance with Medications |

ACCESS AND FUNCTIONAL NEEDS REGISTRY FORM 2018

- 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: _____

Has Difficulty Walking and Requires

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

Transportation Needs

- Car
- Bus
- Wheelchair Van
- Ambulance

Medical Equipment Not Easily Transportable

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

Oxygen Dependent

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

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 _____

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.

ACCESS AND FUNCTIONAL NEEDS REGISTRY FORM 2018

- Limited volunteer nursing, medical assistance, supplies, and equipment 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

ACCESS AND FUNCTIONAL NEEDS REGISTRY FORM 2018

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