

# Special Needs Assessment

New Registration   
Update Information   
Remove from List

## Personal Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Physical Street Address: \_\_\_\_\_  
Mailing Address (if different than physical address): \_\_\_\_\_  
Contact Number(s): \_\_\_\_\_  
Do you presently live in: Apartment \_\_\_\_\_ House \_\_\_\_\_ Mobile Home \_\_\_\_\_  
Primary Language: English \_\_\_\_\_ Spanish \_\_\_\_\_ Other: \_\_\_\_\_  
TDD/TTY (for hearing impaired): Yes \_\_\_\_\_ No \_\_\_\_\_  
Caregiver Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Home Health Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_  
Neighbors Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## Disaster Plan

What is your primary disaster plan?  
\_\_\_\_ Stay with family or others. If so, please give the name, address & contact number of whom you plan to stay with: \_\_\_\_\_  
\_\_\_\_ Stay at home. If you choose to stay at home, will you be alone?  
\_\_\_\_ Yes \_\_\_\_ No  
Do you have a generator? \_\_\_\_ Yes \_\_\_\_ No  
\_\_\_\_ Evacuate to a shelter.  
*(If going to a shelter, a caregiver must accompany you to the shelter and stay with you while there.)*  
Do you have transportation to get to a shelter? \_\_\_\_ Yes \_\_\_\_ No  
If no, what are your transportation needs? \_\_\_\_ Car \_\_\_\_ Van with lift \_\_\_\_ Ambulance  
\_\_\_\_ How many pets do you have?  
Do you have arrangements in place for your pets during an emergency? \_\_\_\_ Yes \_\_\_\_ No

## Disabilities

Do you need assistance with walking?  
\_\_\_\_ Walks Unassisted \_\_\_\_ Walks with Assistance \_\_\_\_ Wheelchair \_\_\_\_ Bedridden  
Check any of the following disabilities which apply to you?  
\_\_\_\_ Hearing Impaired \_\_\_\_ Sight Impaired \_\_\_\_ Speech Impaired  
\_\_\_\_ Contagious Disease \_\_\_\_ Use Service Animal  
Other: \_\_\_\_\_

**SPECIAL MEDICAL NEEDS:**

**Special Needs Include any and/or all of the Following:**

1. Individuals with severe respiratory problems (oxygen or ventilator dependent) that require a power source and/or ambu-bag.
2. Individuals dependent on airway suctioning (tracheotomy).
3. Individuals on IV (intravenous) therapy.
4. Individuals requiring tube feeding.
5. Individuals requiring wound care or help with injections on a daily basis.
6. Individuals who are diabetic and require assistance with insulin.
7. Individuals with physical or mental conditions that require daily medical supervision

**Circle any/all medical needs that apply to you as defined by the categories listed above.**

**1                      2                      3                      4                      5                      6                      7**

**Other Medical Needs: (Check Yes or No)**

	Yes	No		Yes	No		Yes	No	Frequency
Life Support			Colostomy (self)			Wound Care			
Feeding Tube			Colostomy (w/assistance)			Dialysis			
Insulin (self)			Illeostemy (self)			IV Fluids			
Insulin (w/assistance)			Illeostemy (w/assistance)			Suction Unit			
Ventilator			Portable Oxygen Tank						
24 hour caregiver			Concentrator (for oxygen)			Oxygen			

If you receive oxygen, who is your oxygen provider:

\_\_\_\_\_

Do you have medical equipment that requires power?    \_\_\_\_ Yes    \_\_\_\_ No

Do you have supplies or equipment that you cannot transport?    \_\_\_\_ Yes    \_\_\_\_ No

If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

**I certify that the above information is correct. I understand I am responsible for all expenses associated with medical evacuation and shelter at a hospital. I hereby authorize Greene County Social Services to release, use or disclose this information to other emergency response or human services agencies or officials. I also give law enforcement permission to enter my home in case of an emergency.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_