

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** _____