

# Suffolk County Special Needs Registry Application

First Name  Middle Initial  Last Name

Apt-Lot number  What Floor?  Address

Township-Halmet  State  Zip Code

Year Round  Yes  No Nearest Cross St.

Mailing Address if Different  Township-Hamlet

State  Zip Code  Home Phone   TDD/TTY Device

Cell Phone   TDD/TTY Device

E-mail Address

Primary Language  English  Spanish Primary Language Other

Gender  Height Ft.  Height Inches  Weight  DOB

If Married Spouse's Name  If Married is your Spouse Registered?  Yes  No

Spouse's Cell Phone  Spouse's E-mail Address

Type of Residence  Single Family  Apartment  Mobile Home  
 Home-Duplex  Condo  Other

Other Type of Residence

Number of Cats in Home  Number of Dogs in Home  Other Type of Pet

Number of Other Type Pets  Service Animal

Pets cannot be accommodated at special needs shelters; so please be sure to make arrangements, in the event you need to evacuate your residence, for your pets to stay with a relative, friend or at a commercial boarding location.

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In case of an emergency evacuation, where do you plan to go?

I have made arrangement to stay with relatives, friends, a community organization, or hotel in a non-evacuation area.

I am unable to make other arrangements and must go to an evacuation center.

Do you need transport to a shelter?  Yes  
 No

Do you need a wheelchair lift?  Yes  
 No

Do you require a stretcher?  Yes  
 No

Do you require any additional Mobility Aids?

Are you receiving Home Health Care?  Yes  
 No

If Yes Name of Agency

If you have a caregiver, please list their name and phone number.

Name of Care Giver

Care Giver Phone

You are entitled to have one person accompanying you to the shelter

One person will accompany me to the shelter

I will be unaccompanied when I go to the shelter

### Check all that apply about your conditions

Alzheimer's -Note Stage-

Amyotrophic lateral sclerosis (ALS)

Fractured Bones with Pin Care

Back Injury

Full Paralysis

Blind, Hearing or Speech Impaired

Heart Conditions

Cerebral Palsy

High Blood Pressure

Colostomy or Ileostomy -Specify-

Contagious Disease -Specify-

Epilepsy or Other Seizures - Specify

Incontinence

Cognitive Disability

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**Check all that apply about your conditions**

- Mental Illness -Specify-
- Special Diet -Specify-
- Pregnant in 7th month or more.
- Severe Arthritis
- Other Condition -Specify-

**Are you dependant on any of the following?**

- Ambulatory with assistance
- Walker/ Cane/ Crutches
- Wheelchair on occasion
- Catheters
- Insulin
- Oxygen Dependent
- Oxygen Intermittent
- Dialysis HEMO
- Dialysis Peritoneal
- I am dependent on electricity to live.
- Non - Ambulatory (bedridden)
- Wheelchair Bound
- NG tube/CV infusion site/tracheostomy
- IV Medication
- Respirator
- CPAP, BiPAP
- Dialysis - no dialysis will be available at the shelter
- Pregnant in 7th month or more

If so, briefly explain

**List all of your medications:**

Name of Medication	<input type="text"/>	Dosage	<input type="text"/>
Name of Medication	<input type="text"/>	Dosage	<input type="text"/>
Name of Medication	<input type="text"/>	Dosage	<input type="text"/>
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Allergies

You must give name & phone number of a neighbor or friend that we may use for an alternate contact. This person must live in your area & must be aware that they are listed as an alternate contact

**Emergency Contacts**

Name

Address

Township/ Hamlet  State

Zip  Home Phone  Work Phone

Cell Phone  E-Mail Address

**Additional Contact**

Name

Address

Township/ Hamlet  State

Zip  Home Phone  Work Phone

Cell Phone  E-Mail Address

**Additional Contact**

Name

Address

Township/ Hamlet  State

Zip  Home Phone  Work Phone

Cell Phone  E-Mail Address

### Additional Contact

Name

Address

Township/ Hamlet

State

Zip

Home Phone

Work Phone

Cell Phone

E-Mail Address

I authorize  I do not authorize emergency personnel to enter my home during search and rescue personnel to enter my home during search and rescue operations if necessary to assure my safety and welfare following a disaster.

Comments that are Important

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet attached and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I also grant permission to emergency personnel to enter my home following an emergency if deemed necessary by proper authorities. I understand that this registration is voluntary and hereby request registration in the Special Needs Program. I understand that all information given will be held in strict confidence and will be used for emergencies only.

I Agree