Albany County Sheriff's Office

Community and Emergency Services
58 Verda Avenue
P.O. Box A
Clarksville, NY 12041
Phone: (518) 720-8030 * Fax: (518) 720-8031

Evacuation Functional Needs 911 Registry Application

_____

Last First Middle Initial

_____

Address Apt.# City State Zip Code

_____

Home Phone /TTY Cell Phone Email

Sex☐Male ☐Female Date of Birth:_____/_____/_____ Weight: _____ Height:_____

Social Security # **(optional)**:_____

Number of relatives living with you who will accompany you to a shelter if need be: _____

Residence Type:☐Private Home☐Apartment/Condo☐Mobile Home☐High-rise
☐Group Home ☐Retirement Home☐Duplex ☐Dorm
Name of Complex/Subdivision:_____
Yearly resident?☐Yes☐No If no, from _____to_____

Do you have pets?☐Yes☐No
Do you have arrangements for them in an emergency?☐Yes☐No
Please be advised that pets may NOT accompany you to a shelter unless they are service animals.

Evacuation Information: PLEASE GIVE NAME AND PHONE NUMBER BELOW OF SOMEONE WE MAY CALL IF WE ARE UNABLE TO REACH YOU DIRECTLY:
Will you require evacuation assistance?☐Yes☐No
Do you: ☐Care for yourself **or** ☐ Regularly have assistance from a caregiver
Name of Caregiver: _____ Phone #:_____Cell #_____
Address:_____ City:_____ Zip:_____

Transportation (check all that apply)
☐ I will provide my own transportation☐I can get to a bus pickup point☐
☐ I am ambulatory,☐with assistance ☐I Need a wheelchair lift equipped vehicle
☐ I can transfer from a wheelchair to a seat ☐I am bedridden and require stretcher transport

Is Your Disability: ☐Temporary **or** ☐Permanent
If temporary, please give a medical release date: _____
Note: unless you notify registry personnel, you will be deleted from registry as of the above date.

Type of Disability (check all that apply**)**
☐ None☐Hearing Impaired ☐require a translator, If so specify:_____
☐ Blind ☐ I have a hearing/seeing service animal which will accompany me
☐ Mental Disability☐Bedridden☐Other:_____

Special Equipment (check all that apply)
☐Wheelchair dependent ☐ collapsible☐non collapsible ☐ Walker/cane
☐Electric Dependent ☐ Portable Oxygen – Hours per day: _____ Litre Flow: _____
☐Other (please describe):_____

(**Over)**

911 Registry

911 Registry

Medications:

☐ Self administered, shelf kept ☐ Intravenous, self administered, shelf kept
☐ Intravenous, self administered, refrigeration required, please list:_____
☐ Non self administered medication required ☐ No medicine
☐ **Medicine Allergy**, if so what medicine(s):_____

What illness do you take medication for (check all that apply):

☐ Heart problems ☐ Blood pressure ☐ Stroke ☐ Diabetes ☐ Breathing problems
☐ Back problems ☐ Seizures/convulsions ☐ contagious diseases ☐ Dialysis, # weekly_____
☐ other (describe):_____

Do you require a special diet? ☐ Yes ☐ No If yes, what type?_____
Type of shelter requested: ☐ Standard ☐ Special Need

Name of Physician: _____ Phone: _____

Do you have any other comments or suggestions that may assist us in your care during evacuation?
_____

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 herby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue.

I understand my participation in this registry is voluntary and all information maintained will be strictly confidential, used only for emergency purposes and hereby request registration in the Albany County Evacuation Functional Needs 911 Registry.

I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation.

The information contained herein is true and correct to the best of my knowledge. I understand that assistance will be provided only for the duration of emergency, and that alternative arrangements should be made in advance in case I am not able to return to my home.

I understand, based on the information I have provided that I may or may not be assigned to a special needs unit based on the criteria slated in the information I provided. I understand that I am responsible for assisting in the provision of any prescription medications, oxygen supplies, medical equipment, and dietary items I may require during the emergency.

Registrant Signature: _____Date: _____
Caregiver: _____ Date: _____ (*if registrant is unable to sign)*
Relationship to Registrant (if any):_____

Please Mail form back to: Albany County Sheriffs Office
Community and Emergency Services
58 Verda Ave, P.O. Box A
Clarksville, NY 12041
Attn: Linda Nash

*Please contact **Linda Nash (518) 720-8030** in the event any of the above information changes at any time, such as an address change, medical change, etc. You will be contacted by our office if we have any questions regarding your application, and periodically contacted to update our records.*

Agency Use only:

Date Registered:
Updated: _____

Click Button to EMAIL