

## **Upper Township Office of Emergency Management VOLUNTARY SPECIAL NEEDS PROGRAM REGISTRATION**

### **INTRODUCTION**

Upper Township Emergency Management officials may order or recommend an evacuation of specific areas of the Township for reasons that include: natural disasters such as a hurricane, fire, or flood; man made incidents, rail, or highway accidents; or technological disasters such as hazardous material release or nuclear power plant incidents.

Special Needs is a voluntary program that provides evacuation assistance and sheltering to residents during such times. Transportation assistance can be provided for individuals in an ordered evacuation area who may not have a means of transport to a Red Cross Shelter, and for those requiring health or medical considerations.

### **WHO IS ELIGIBLE?**

UPPER TOWNSHIP RESIDENTS:

- Requiring transportation to and from a designated emergency shelter;
- Residents in an ordered evacuation area, recommended evacuation area, or unsafe residence;  
or
- Requiring, within the limits of services provided, assistance with mobility, oxygen, routine medication administration, routine health monitoring, etc.

**Proper registration requires that registration forms be filled out completely. Forms that are not filled out completely will be returned. Older versions of this form and forms from other programs do not contain the required registration data and will not be accepted.**

**Residents requiring greater levels of assistance than can be provided by this service such as a hospital bed, hemodialysis, life support equipment, IV chemotherapy, full ventilator, etc. are advised to make alternative plans with the assistance of a physician or health care professional.**

### **HOW TO REGISTER**

Upper Township residents may register by completing the Special Needs Registration Form available at Township Hall.

Individuals residing in nursing homes or assisted-living facilities are not eligible for this program because of these facilities are required to maintain approved Emergency Plans that address resident care during times or emergencies.

Upon receipt of a **signed and completed** special needs form by the Office of Emergency Management each individual will be entered into the confidential database. **Registration must be renewed each year.** The Office of Emergency Management will automatically mail new registration forms to registered individuals prior to the beginning of hurricane season on June 1. **Participants failing to re-register within 60 days of the mailing date will be dropped from the program.**

## **EVACUATION ORDER AND SHELTER ACTIVATION**

The Office of Emergency Management will coordinate any evacuation and determine what areas of Upper Township will be affected.

- **Registered residents will be notified via the Township's out-call telephone system.**
- **Registrants should have their belongings ready for travel. Registrants requiring transportation DO NOT need to call the Office of Emergency Management.**
- **Residents transporting themselves can proceed to the designated Shelter.**

The time of shelter activation will depend upon the type of event. For example, in a hurricane evacuation the shelter may be opened as much as 24 hours prior to landfall. The Office of Emergency Management will arrange pick up, transport and return registrants who require transportation. Upper Township will administer the operation and staffing of the Special Needs Shelter upon activation.

### **WHAT SHOULD I BRING WITH ME?**

The Special Needs Shelter will provide cots. Companions may accompany registrants but due to space limitations, only one companion per registrant is permitted. Considerations must be given to what you can and cannot bring with you.

**Pets other than service animals (such as Guide Dogs) are not allowed in emergency shelters.**

Listed below are typical supplies and articles that are allowed at the shelter.

- Medication to last seven (7) days
- Oxygen/oxygen supplies, including O2 concentrator with extension cord.
- Special Diet foods.
- Bedding (blankets, sheet, pillow) – Cots will be provided at the Special Needs Shelter.
- Air Mattress or cushioned sleeping pad.
- Two (2) changes of clothes.
- Personal hygiene items (i.e. diapers, deodorant, toothbrush, etc.)
- Important papers in a zip-lock bag (i.e. insurance papers, credit card, money)
- Plastic bags for soiled items.

### **POINTS TO REMEMBER**

- Registrant's name should be written on all personal items.
- Alcoholic beverages of any kind are not permitted at any shelter.
- Special Diets CANNOT be accommodated – You must bring special foods.
- Smoking is not permitted in emergency shelters. The Health Department will designate one outdoor smoking area at the Special Needs Shelter.
- Law enforcement will be present at the shelter, but individuals are responsible for safeguarding their own personal items.
- Don't wait for the last minute to assemble your personal effects and supplies.

**KEEP THIS PAGE FOR REFERENCE. MAIL ONLY THE COMPLETED FORM TO:**

**Upper Township Special Needs Registry  
P.O. Box 205  
Tuckahoe, New Jersey 08250**

**Upper Township Emergency Management**  
**VOLUNTARY SPECIAL NEEDS REGISTRATION FORM**  
2100 Tuckahoe Road Petersburg, NJ 08270 609 628-2011

PLEASE PRINT ON ALL PAGES

TODAY'S DATE: \_\_\_\_\_

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**PERSONAL DATA**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt/Lot No. \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Residence Type: \_\_\_ Private Home \_\_\_ Apartment/Condominium \_\_\_ Manufactured/Mobile Home

Name of Complex/Subdivision or Development: \_\_\_\_\_

Emergency Contact Person not living with you:

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

Alt. Phone: \_\_\_\_\_

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**EVACUATION REQUIREMENTS**

Type of transportation:

\_\_\_ No transportation Needed \_\_\_ Bus \_\_\_ Wheelchair Vehicle \_\_\_ Ambulance

Due to limited space at the shelter, one additional person will be allowed with the client.

\_\_\_ No one will accompany me \_\_\_ Yes, someone will accompany me (Fill in below)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL CARE**

Are you a Hospice Patient?  Yes  No  I do not need care from a nurse.

Name of Home Health Care Agency: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Oxygen Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

I will need the following care from a nurse.

Explain: \_\_\_\_\_

I understand I need to bring all my medications in marked bottles and all medical supplies I use for my care.

I understand that electricity cannot always be guaranteed, and that I will bring full oxygen tanks for support my need.

**MEDICAL HISTORY (Please check all that apply)**

Are you allergic or sensitive to any medication(s)?  Yes  No

Type: \_\_\_\_\_

<b><u>Mobility</u></b>	<b><u>General</u></b>	<b><u>Other Impairments</u></b>
<input type="checkbox"/> I walk without help	<input type="checkbox"/> Arthritis/Severe	<input type="checkbox"/> Deaf
<input type="checkbox"/> I use a walker	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Blind <input type="checkbox"/> Guide Dog?
<input type="checkbox"/> I use a cane	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Open wounds that need dressing changes
<input type="checkbox"/> I use a wheelchair	<input type="checkbox"/> Diabetes	How often? _____
<input type="checkbox"/> Bedridden	<input type="checkbox"/> Insulin dependant	<input type="checkbox"/> Contagious Condition? Describe: _____
<b><u>Respiratory Support</u></b>	<input type="checkbox"/> Oral Medication	_____
<input type="checkbox"/> Oxygen Support	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Incontinence
<input type="checkbox"/> hours per day	<input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Ostomy
<input type="checkbox"/> Liter flow	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Memory Impairment
<input type="checkbox"/> I use a Nebulizer	<input type="checkbox"/> Home Dialysis	<input type="checkbox"/> OTHER: Please be specific
<input type="checkbox"/> times a day	How many times a week?	_____
<input type="checkbox"/> I understand I need to bring _____ enough oxygen to support my needs during travel	_____ Dialysis Center	_____
	_____	_____

Listed below are some of the conditions that cannot be accommodated and are thus not eligible for evacuation to the shelter.

**MAKE OTHER ARRANGEMENTS IN ADVANCE – OBTAIN ASSISTANCE FROM YOUR PHYSICIAN OR HEALTH CARE PROVIDER.**

<b>Requires Life Support Equipment</b>	<b>Hemodialysis</b>
<b>IV Chemotherapy</b>	<b>Requires Hospital Bed</b>
<b>Ventilator</b>	

Federal Public Law 104-191, Health Insurance Portable and Accountability Act (HIPAA) of 1996, establishes your right to privacy regarding disclosure of certain confidential health care information, known as Protected Health Information (PHI). Upper Township Emergency Management Agency is required by HIPAA to protect your personal health information and to ensure its confidentiality. We respect your right to privacy and administer all Special Needs data under strict policies of confidentiality. Should you wish to inspect your PHI in the confidential database or learn more about your privacy rights under HIPAA, please contact the Upper Township Emergency Management Special Needs Program (Contact information provided below)

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Upper Township Emergency Management Agency will determine which emergency evacuation assistance, if any, this program may be able to provide. I understand that assistance will only be provided 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 changes associated with any hospital stay. I understand my right to personal medical privacy under HIPAA and grant permission to medical providers, transportation agencies, and others as necessary to provide care and disclose any information necessary to respond to my needs.

_____	_____
<b>Signature</b>	<b>Date</b>
_____	_____
<b>Representative Signature (if patient is unable to sign)</b>	<b>Date</b>

If the person filling out this form is not the patient, please answer the following:  
Patient notified of registration? \_\_\_\_\_ YES \_\_\_\_\_ NO

Name: \_\_\_\_\_ Relationship/Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Please return this form to:

**Upper Township Special Needs Registry  
P.O. Box 205  
Tuckahoe, New Jersey 08250**

**Phone: 609-628-2011  
Fax: 609-628-3092**