STEUBEN COUNTY EMERGENCY SERVICES

Steuben County's Access and Functional Needs Registry

For many years Steuben County Emergency Services has had a registry to allow citizens with access or functional needs and facilities that serve those needs an opportunity to provide information to emergency response agencies, so first responders can better plan to serve them in a disaster or other emergency. This registry is being revised and updated to better serve the access and functional needs population.

For the purpose of this program, an individual with access or functional needs is someone who cannot receive, understand or act upon emergency protective orders.

The information collected here will not be available to the public. The information will be held securely and only accessed for the purpose of emergency response and planning.

Please be as complete as possible in your responses. You will be contacted via mail or email to verify and ensure the information provided is correct and to make any necessary changes. Individual surveys will be archived after one year if not verified and facility surveys will be archived after six months if not verified.

Mail completed form to:

Steuben County Office of Emergency Services
3 E. Pulteney Square, Bath, NY 14810

REMEMBER: The first line of defense against the effects of a disaster is personal preparedness. During an emergency, the government and other agencies may not be able to meet your needs. It is important for all citizens to make individual emergency plans and prepare for their care and safety in an emergency.

Steuben County's Access & Functional Needs Registry is...

- ☑ Free
- ☑ Voluntary
- ☑ Strictly confidential
- ☑ Protective of your privacy
- ☑ A way to protect you in a major emergency

Steuben County Office of Emergency Services

Timothy D. Marshall, Director

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3 E Pulteney Square

Bath, NY 14810

Phone: 607-664-2910

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Your Personal Information:

If your address does not reflect your actual physical location, then describe where the location is that emergency personnel can find you.

FIRST NAME:_____ MI:_____

LAST NAME:_____ SUFFIX:_____

ADDRESS:_____

ADDRESS LINE 2:_____

NEIGHBORHOOD:_____

CITY:_____ STATE:_____ ZIP CODE:_____

COUNTY:_____ MUNICIPALITY:_____

How is my Municipality different from my City?

The entry in the City field should be the same as you would commonly use in your mailing address. The entry in the Municipality field should be where the address is actually located. For example, someone may live in the Town of Erwin (their town or municipality), but their mail may be addressed to Painted Post, NY (their Post Office).

Your municipality will also be the local government entity to which you pay taxes.

RESIDENCE TYPE (CHECK ONE):

☐ SINGLE FAMILY UNIT ☐ MULTI-FAMILY UNIT ☐ MOBILE UNIT ☐ APARTMENT BUILDING

PRIMARY PHONE:_____ EXT.:_____

IS PRIMARY PHONE TTY/TTD (TELETYPE DEVICE): ☐ YES ☐ NO

SECONDARY PHONE:_____ EXT.:_____

☐ I DO NOT HAVE A PHONE

EMAIL:_____

DATE OF BIRTH (MM/DD/YYYY):_____ HEIGHT: (FEET)_____ (INCHES)_____

☐ CHECK IF WEIGHT IS OVER 300 POUNDS (LBS.) GENDER (CHECK ONE): ☐ MALE ☐ FEMALE

EYE COLOR:_____

Why do you need my height and weight?

It is important that emergency responders be aware of any condition you have that requires either special equipment or additional personnel to safely evacuate you. This includes gathering information on your size (both height and weight).

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Emergency Contact Information

Please provide the requested information for an individual with whom we can discuss your situation in the event that an emergency necessitates this.

PRIMARY CONTACT:

FIRST NAME:_____ MI:___ LAST NAME:_____ SUFFIX:_____

ADDRESS:_____

ADDRESS LINE 2:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMERGENCY CONTACT'S RELATIONSHIP TO YOU (CHECK ONE):

☐ NONE ☐ FRIEND ☐ FAMILY MEMBER ☐ NEIGHBOR ☐ CAREGIVER ☐ OTHER

EMAIL:_____

PRIMARY PHONE:_____ EXT.:_____

SECONDARY PHONE:_____ EXT.:_____

☐ MEDICAL INFORMATION PERMISSION (PLEASE CHECK IF YOU PROVIDED CONSENT TO THIS EMERGENCY CONTACT TO RELEASE MEDICAL INFORMATION TO EMERGENCY PERSONNEL.)

SECONDARY CONTACT:

FIRST NAME:_____ MI:___ LAST NAME:_____ SUFFIX:_____

ADDRESS:_____

ADDRESS LINE 2:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMERGENCY CONTACT'S RELATIONSHIP TO YOU (CHECK ONE):

☐ NONE ☐ FRIEND ☐ FAMILY MEMBER ☐ NEIGHBOR ☐ CAREGIVER ☐ OTHER

EMAIL:_____

PRIMARY PHONE:_____ EXT.:_____

SECONDARY PHONE:_____ EXT.:_____

☐ MEDICAL INFORMATION PERMISSION (PLEASE CHECK IF YOU PROVIDED CONSENT TO THIS EMERGENCY CONTACT TO RELEASE MEDICAL INFORMATION TO EMERGENCY PERSONNEL.)

ADDITIONAL CONTACT INFORMATION:

PHYSICIAN'S NAME:_____

PHYSICIAN'S PHONE NUMBER: (_____)_____

HOME HEALTH CARE AGENCY:_____

AGENCY'S PHONE NUMBER: (_____)_____

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Evacuation Information

If there were an emergency requiring evacuation, the individual may have difficulty evacuating or being notified of the need for evacuation because of the following condition(s): (Check all that apply):

- ☐ Sight Impaired
- ☐ Hearing Impaired
- ☐ Speech Impaired
- ☐ Physically Impaired
- ☐ Completely Bedridden
- ☐ Mentally/Memory Impaired
- ☐ Dementia/Alzheimer's
- ☐ Dialysis
- ☐ Requires Constant Skilled Nursing Care
- ☐ Autism
- ☐ Other Reason for Needing Assistance:_____

_____

_____

- ☐ Needs an interpreter or TTY
- ☐ Lives alone
- ☐ Has Lifeline or Medic Alert device (Specify Provider):

_____

_____

DOES NOT HAVE:

- ☐ I do not have access to a motor vehicle
- ☐ I do not have a radio or television
- ☐ I do not have a telephone

- ☐ I do not speak English (choose one):
  - ☐ Arabic
  - ☐ Chinese
  - ☐ French
  - ☐ German
  - ☐ Greek
  - ☐ Gujarathi
  - ☐ Hindi
  - ☐ Italian
  - ☐ Japanese
  - ☐ Korean
  - ☐ Polish
  - ☐ Portuguese
  - ☐ Russian
  - ☐ Spanish
  - ☐ Tagalog
  - ☐ Other

I have difficulty walking and require:

- ☐ Walker/cane
- ☐ Standard wheelchair
- ☐ Motorized wheelchair
- ☐ Attendant to assist in ambulating

I require medical equipment that is not easily transportable:

- ☐ Oxygen concentrator or cylinder
- ☐ Ventilator
- ☐ Suction machine
- ☐ Other equipment (please specify):_____

_____

_____

_____

Relocation Assistance

This information will be helpful in determining the assistance that the person requires.

1. Are ALL of the support needs resulting in the need for evacuation assistance temporary? (Example: you are bedridden due to pregnancy difficulties, but are expected to be fully recovered after the baby is delivered.) Check one.

   a. ☐ Yes ☐ No, the condition(s) are expected to be permanent.

   If the condition is temporary, please provide an estimated date of recovery. Month: _____ Year:_____

2. Are you a seasonal resident? ☐ Yes ☐ No

   a. I am a seasonal resident **from**:_____ and **to**:_____

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Relocation Assistance continued...

3. DO YOU REQUIRE EVACUATION ASSISTANCE 24 HOURS A DAY? ☐ YES ☐ NO

   a. IF YOU DO **NOT** REQUIRE EVACUATION ASSISTANCE 24 HOURS A DAY, WHEN DO YOU NEED HELP? (ENTER TIME BELOW.)

   FROM:_____ ☐ A.M. ☐ P.M. **TO:**_____ ☐ A.M. ☐ P.M.

4. DO YOU HAVE A 24 HOUR CAREGIVER? ☐ YES ☐ NO

   b. WILL THE CAREGIVER TRAVEL AND STAY WITH YOU? ☐ YES ☐ NO

5. DO YOU HAVE MEDICATIONS THAT MUST BE TAKEN WITH YOU IF EVACUATED? ☐ YES ☐ NO

Service Animals/Pets

Please list any service animals/pets in your care that will also require assistance. Enter up to 8 animals. Place a checkmark in the Service Animal column if the animal is a service animal. Place a checkmark if you have a carrier cage, leash or muzzle for each animal.

SERVICE ANIMAL	NAME	TYPE	BREED / DESCRIPTION	WEIGHT	CARRIER CAGE?	LEASH?	MUZZLE?

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Additional Comments/Information

Please enter any additional information that may be useful for our emergency personnel who will be assisting you during an evacuation.

_____

_____

_____

Thank you for completing our survey. The information you provided will be of great value in helping emergency responders plan for your safety.

It is crucial to our response efforts that the information you provide be as accurate and up to date as is possible. You will be contacted via mail or email annually to verify and ensure the information provided is correct and to make any necessary changes. Individual surveys will be archived after one year if not verified and facility surveys will be archived after six months if not verified.

I hereby consent to have my name placed voluntarily in the Steuben County Registry of Person with Access or Functional Needs. The Registry is managed by the Steuben County Office of Emergency Services. I understand the information I have provided in this application is health information that is protected from disclosure by the Health Insurance Portability and Accountability Act, except upon specific authorization and release, which I hereby grant to the Steuben County office of Emergency Services. I understand this information may be shared with the Enhanced 911 Department for Emergency dispatch purposes.

( ) I hereby Authorize ( ) I Do Not Authorize emergency response personnel to enter my home during an emergency to assure my safety and welfare.

_____ _____

Signature Date

Information will be kept confidential and only used in the event of an emergency or natural disaster. It does not guarantee that agencies will be able to provide assistance in every type of emergency. Steuben County shall not be held liable for any claim based upon good faith failure to exercise or perform a function or duty on the part of any officer or employee in carrying out a local disaster preparedness plan.