VOLUNTARY NEEDS REGISTRY

Completing the following form will enable the Health Department to better plan for your needs in the case of an emergency.

This is a voluntary form that is not a guarantee of assistance but a tool for planning for potential options for emergency response agencies.

PLEASE PRINT CLEARLY

Today's date _____ PLEASE CHECK IF: _____ Initial Application _____ Update

Completed by_____ Relationship to patient_____

Last Name _____ First Name _____ Middle Initial_____

Male _____ Female_____DOB ____/____/_____

Address _____ Apt#_____

City _____ Zip Code _____

Residence Type: Single Family Home _____ Duplex _____ Apartment _____Condo _____

Camper/RV _____ Mobile Home _____ Floor you live on _____ Other _____

Mailing Address (if different from above)_____

Telephone: Home (_____) _____ Alternate Phone (_____)_____

Email Address: _____

I speak: English _____ Spanish _____ Other _____

Emergency Contact: Name_____Phone_____

Care Giver: Name_____Phone_____

Legal Guardian: Name_____Phone_____

Service animal: Type _____ Name _____

Function _____

Other pets?: _____

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COMMUNICATION NEEDS: Please describe problems with the following

Speaking _____ Reading _____

Seeing _____ Hearing _____

Understanding _____ Interpreter needed for_____

MEDICAL NEEDS:

HEIGHT _____ WEIGHT _____ ALLERGIES _____

Type(s) of problems

NEUROLOGICAL _____ MUSCLE _____ BONE _____ HEART _____

SEIZURES _____BREATHING _____ ALZHEIMER'S_____

MENTAL ILLNESS_____ DEVELOPMENTAL DISABILITY _____

OTHER _____

CURRENT MEDICAL CONDITIONS: _____

_____

_____

DO YOU USE ANY OF THE FOLLOWING ?

OXYGEN _____ VENTILATOR _____ CPAP _____ SUCTION _____

IV EQUIPMENT _____ FEEDING TUBE_____ DIALYSIS _____ INSULIN _____

CANE _____ WHEELCHAIR _____ WALKER _____ MEDICINE _____

CRUTCHES _____ HOSPITAL BED _____ BARIATRIC BED_____

OTHER _____

IS YOUR EQUIPMENT OPERATED BY ELECTRICITY? _____

I NEED ASSISTANCE WITH THE FOLLOWING ACTIVITIES OF DAILY LIVING:

MOBILITY: WALKING_____ MOVING BED TO CHAIR_____ BEDBOUND _____

PERSONAL CARE: BATHING _____ DRESSING _____ ORAL CARE _____

TOILETING _____FEEDING _____ WOUND CARE _____ MEDICATIONS _____

OTHER _____

_____

_____

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TRANSPORTATION NEEDS:

I CAN BE TRANSPORTED BY: A REGULAR CAR_____ NEED A WHEELCHAIR VAN _____

NEED AN AMBULANCE _____

MEDICAL CONTACTS:

PHYSICIAN: _____PHONE _____

HOME HEALTH AGENCY: _____ PHONE _____

HOSPICE: _____ PHONE _____

MEDICAL EQUIPMENT/OXYGEN PROVIDER: _____ PHONE _____

DIALYSIS CENTER: _____PHONE _____

PHARMACY: _____ PHONE _____

PLEASE RETURN FORM TO: SUSAN MCFARREN, RN, PHN

MORCHD, 555 LEXINGTON AVE., MANSFIELD, OH 44907

FAX: 419-774-4590 419-774-4541 smcfarren@richlandhealth.org

NOTE: It is the registrant's responsibility to make updates to the form as changes occur.

Please review and sign the following page

This is a voluntary form that is not a guarantee of assistance but a tool for planning for potential options for emergency response agencies.

AUTHORIZATION AND WAIVER:

I UNDERSTAND THAT THE Mansfield/Ontario/Richland County Health Department (MORCHD) has created a Voluntary Needs registry for persons with disabilities or special needs that may be utilized by emergency response agencies. My information or that of a parent, family member, or ward may be included in the registry only by completing the attached form and submitting it to the MORCHD.

I state that the information on this form is true and accurate to the best of my knowledge and has been provided voluntarily. If I am signing on behalf of a parent, family member or ward, I state and represent that I have full legal authority through a valid power of attorney or otherwise to do so.

I understand and also authorize that this information be used to determine potential assistance options, if any, for evacuation and shelter for myself/family in the event of a recognized and/or declared emergency in Richland County. I further understand and have been informed that this is not a guarantee of assistance or preferential consideration in an emergency, but rather a tool for planning for potential options for Emergency Response Agencies and responders.

I understand that it is highly recommended that I have my own emergency plans in place. I have been informed that more information on emergency planning is available at www.richlandhealth.org.

HIPAA PRIVACY RULE: By signing this authorization, I fully authorize and allow the use or disclosure by MORCHD of any and all of my medical and demographic information to other emergency/governmental agencies/facilities. This information may be used for the purposes of planning, evacuation, sheltering, transportation, and care. I understand that this authorization shall expire only upon my written revocation and formal receipt of same by MORCHD.

This form, or portions thereof, may be subject to disclosure under Ohio's public records law. Information that is not public record shall not be released absent a court order.

By signing below, I release and hold harmless on behalf of my parent, family member, ward, and/or myself, the MORCHD, its agents, representatives and employees from any liability or potential liability including but not limited to accidents, injuries, or death, arising out of or related to the information I have provided on the attached Voluntary Needs Registry form regardless of whether the MORCHD or its agents, representatives or employees act negligently.

I have read this Authorization & Waiver, including the general release, fully understand its terms, and voluntarily accept them and/or voluntarily accept them on behalf of my parent., family member or ward. I have been informed that the complete MORCHD notice of privacy practices can be found at *www.richlandhealth.org.*

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name Relationship

_____ _____

Witness Date

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