



Iredell County Special Needs Registry

Dear Iredell County Resident,

The 2000 U.S. Census Bureau says there are 1.5 million people living in North Carolina who have some type of disability. In order to assist residents of Iredell County, a special needs registry has been developed to help Emergency Management know about residents that may have difficulties during a disaster or significant event. You may sign up for the special needs registry if you or someone you love needs additional assistance during times of emergencies or disasters.

The Iredell County Special Needs Registry gives key information to emergency workers in the event of a 911 call and/or during a disaster such as a hurricane, flood, winter storm, power outage, disease outbreak or nuclear event, etc. **Persons on the registry are volunteering for the list and have the choice to agree to, or say no to, assistance.** Filling out this form does not guarantee the signed up person will receive immediate or special aid in an emergency or disaster. People should always have their own emergency plan in place. This registry allows Emergency Service Providers (emergency management, fire departments, law enforcement, public health, etc.) to share this information with one another to help with your recovery. All records are kept confidential.

Eligible people for the list must live in Iredell County AND have at least one of the following:

- Have to have help with daily living actions (dressing, bathing, toileting, etc.)
- Have need of medical observation or aid
- Have a constant or lasting, or easily spread sickness (Tuberculosis, Dementia, etc.)
- Disability and/or homebound
- DO NOT live in a long term facility (Skilled Nursing Home, Assisted Living, or Care Home)

Step 1: To register, please fill out and sign these papers:

- Conditions and Authorizations to Release Information, Including Protected Health Information form
- Special Medical Needs Registry Application

Step 2: Mail the completed forms to:

Iredell County Emergency Management
P.O. Box 788
Statesville, NC 28687

Step 3: Update your information every year or sooner if it changes with Iredell County Emergency Management, 704-878-5353.

You will receive a phone call or mailing once a year to update your information. If your health condition or personal information changes before the annual update, please contact Iredell County Emergency Management at 704-878-5353 to change your information in the registry. Your information will be checked annually. If Iredell County Emergency Management cannot reach you after three attempts each year, your information will be deleted from the registry.

For additional information you can call the Iredell County Emergency Management office at 704-878-5353, Monday-Friday 8am-5pm. Thank you for helping us to assist you in disaster situations.

Respectfully,
David W. Martin, Director
Iredell County Emergency Management

*Enclosed



**CONDITIONS AND AUTHORIZATION TO RELEASE INFORMATION,
INCLUDING PROTECTED HEALTH INFORMATION**

Please read and initial each of the following:

_____ I hereby request that the information I have provided be listed in the State Special
(initial) Needs Registry. I understand that submitting the information to participate in the State Special Needs Registry does not guarantee that I will be included in the Registry.

_____ I understand that my participation in this registry is voluntary and that all
(initial) information that I provide will only be used for disasters and emergency planning and response purposes.

_____ I understand that at any time I may ask that my name be removed from the
(initial) registry by sending a written request to the Division of Emergency Management.

_____ I grant permission to emergency medical providers, transportation providers and
(initial) other emergency responders to enter my residence in an emergency, to provide care and to disclose the information I have provided as needed to respond to my emergency needs. This is not intended to limit a responder's ability to enter or respond to an emergency as allowable by law.

_____ I understand that while registering this information may help emergency
(initial) responders to know and understand my emergency needs, registration does not guarantee any particular emergency services or any level of emergency services during an emergency or disaster.

_____ I understand that I should call 911 if I am in an emergency, even though I have
(initial) submitted information to the registry.

_____ I understand that I am responsible for making my own emergency preparations.
(initial) This may include, but is not limited to, responsibility for establishing communication with family members or caregivers, and the provision of prescription medications, oxygen supplies, medical equipment, and special dietary items that I may require if I am evacuated from my home.

_____ I understand that I am responsible for all expenses associated with my emergency
(initial) medical evaluation and care.

_____ I understand that I can bring my service animal to an emergency shelter, but I am
(initial) responsible for the feeding and care of my animal.

_____ I understand that it is my responsibility to update the information I have provided
(initial) at least once a year or when my information changes, whichever occurs first.



_____ I grant permission to medical providers, transportation agencies, and others as
 (initial) necessary to provide care and disclose any information necessary to respond to
 my needs.

_____ I understand that assistance will only be provided for the duration of the
 (initial) evacuation, emergency or disaster and that alternative arrangements should be
 made in advance in the event I am not able to return to my home.

_____ I understand that assistance will only be provided for the duration of the
 (initial) evacuation or emergency and that alternative arrangements should be made in
 advance in the event I am not able to return to my home.

_____ I understand that in the event I am not able to return to my home that I will be
 (initial) responsible for any additional transportation or hospital expenses.

_____ I understand that upon order or recommendation to evacuate my residence,
 (initial) if I have requested transportation, I will receive advance notice, by phone, of the
 date and time to expect to be picked up for transport to a shelter.

_____ If I decline transportation when a transporter arrives, I understand that I may not
 (initial) have another opportunity to obtain this service.

_____ I understand that based on this information and the data I have provided;
 (initial) the Division of Emergency Management will determine if any emergency
 evacuation assistance will be provided.

_____ I understand that power is not guaranteed, due to unforeseen power fluctuations
 (initial) or power failures.

I understand that completing this form and including my information in the State Special Needs Registry DOES NOT create a contract for services. Neither the entities or individuals that have created or maintained this registry or collected information for this registry, nor any entity or individual that may utilize the information contained in the registry including but not limited to, the Department of CCPS, Division of EM, public health authorities, human services agencies, emergency personnel and volunteers, warrant that assistance will be provided to you during an emergency or disaster.

I understand that participation in this registry is voluntary and this it is my duty and responsibility to update my information on this registry. By completing this registration form and including the information in the State Special Needs Registry, I hereby confirm and attest that the information provided in this registration is correct and that should the information that I have provided change, I will promptly update the registry. By completing this registration form and including the information in the State Special Needs Registry, I also hereby warrant that the information has been provided



voluntarily and that if I have required assistance to complete this form that I have consented to the assistance provided. By completing this registration form and including the information in the State Special Needs Registry, I also hereby waive any and all claims which relate to the collection, maintenance or use of the information I have supplied which may be asserted against the entities or individuals that have created or maintained this registry or collected information for this registry and any entity or individual that may utilize the information contained in the registry including but not limited to the Department of CCPS, Division of EM and emergency personnel and volunteers.

I understand that my participation in the State Special Needs Registry is voluntary and that all information I provide, including any Protected Health Information, will be treated as confidential, but that under some limited circumstances the information may be released without my permission as allowable by federal or state law.

I further understand that the information I provide will only be released to the Department of CCPS, Division of EM, the County of Iredell and public health authorities, human services agencies, emergency responders, managers and planners, and those individuals who manage the Registry database.

I understand that the information that I have provided to the Registry will only be used in the following circumstances: to respond to disaster-related events; to respond to emergency needs; for evacuation and recovery efforts; and for disaster planning purposes.

I understand that under some limited circumstances the information may be released without my permission as allowable by federal or state law.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

I understand that I, or my personal representative, is entitled to receive a copy of the completed authorization form upon request. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and submit my written revocation to Department of CCPS, Division of Emergency Management. I understand that the revocation will not apply to information that has already been released. I also understand that once information is released to others, it may be re-disclosed to individuals or organizations not subject to state and federal privacy and confidentiality laws and may not be protected.

I have had full opportunity to read and consider the contents of this Authorization. I understand that, by signing this form, I am confirming my authorization that the Department of CCPS, Division of Emergency Management may disclose to the person(s)/organization(s) named in this form the information described in this form.



I certify that the above information is correct. I hereby authorize the Department of CCPS, Division of EM, to release, use, or disclose this information to other emergency response or human service agencies or officials and to include this information in the State Special Needs Registry. I also give law enforcement permission to enter my home in case of an emergency. I understand that I have the right to revoke this permission by notifying Department of CCPS, Division of EM and asking that my name be removed from the special needs registry.

(Signature)

(Date)

If the person filling out this form is not the patient, please answer the following:

Name: _____

Phone: _____

Relationship/ Agency: _____



Iredell County Special Needs Registry

REQUIRED Personal Enrollment Data:

(One Person Per Form, Please Print)

Date of Application: _____

New Application or Update of Existing Application

(Circle one)

Last Name: _____ First Name: _____

Middle: _____ Sex: M F Weight: _____

Street Address: _____ Apt.: _____

City: _____ Zip Code: _____

Mailing Address: _____

(if different from above)

City: _____ Zip Code: _____

Primary phone: (____) ____-_____

Alternate phone number: (____) ____-_____

Primary Language: _____

Name of Subdivision, Mobile Home Park, Apartment Building:

Living Situation:	<input type="checkbox"/>	Living Alone	<input type="checkbox"/>	Living with Parents	<input type="checkbox"/>	Living with Spouse/Significant Other
	<input type="checkbox"/>	Living with Children	<input type="checkbox"/>	Other (please explain below)		



Medical History (please check all that apply)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Memory Impaired <i>(explain below)</i>	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma/Emphysema (COPD)	<input type="checkbox"/> Mental Health Condition <i>(explain below)</i>	<input type="checkbox"/> Special Dietary Needs <i>(explain below)</i>
<input type="checkbox"/> Bedridden	<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Speech Impaired
<input type="checkbox"/> Developmentally Disabled	<input type="checkbox"/> Oxygen Concentrator or Ventilator	<input type="checkbox"/> Suction Machine
<input type="checkbox"/> G-Tube Feeder	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Vision Impaired
<input type="checkbox"/> Insulin Dependent	<input type="checkbox"/> Physically Disabled	<input type="checkbox"/> Walker
<input type="checkbox"/> IV Medication	<input type="checkbox"/> Portable Oxygen Machine	<input type="checkbox"/> Wheelchair Bound
<input type="checkbox"/> Medications <i>(explain below)</i>	<input type="checkbox"/> Refrigeration for Medication(s)	
<input type="checkbox"/> Other <i>(explain below, use additional paper if necessary)</i>		



Disaster Plan

If you require a special diet and must go to a shelter be prepared-pack and bring with you the appropriate foods.

Stay with a friend/family member Stay at home Evacuate to shelter

Require transportation to a shelter (please specify type of transportation below) Will bring a service animal or pet to the shelter

Other (please explain)

Emergency Contact Information

Emergency Contact Name: _____ Home Phone: (____) _____-_____

Work Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Medical Provider Information

Physician Name: _____ Phone: (____) _____-_____

Pharmacy Name: _____ Phone: (____) _____-_____

Home Health Agency (or personal caregiver): _____ Phone: (____) _____-_____

Respiratory Equipment Provider (if applicable): _____ Phone: (____) _____-_____