

# Buncombe County Special Needs Registry Application

The Special Needs Registry provides vital information to emergency responders in the event of a 9-1-1 call and/or during a widespread disaster (e.g. hurricane, flood, blizzard, power outage, disease outbreak). This program is voluntary and individuals on the registry have the option to accept or deny assistance. Completion of this form in no way guarantees that the registered individual will receive immediate or preferential treatment in a disaster.

**Individuals should maintain a personal emergency plan.**

## Personal Information **PLEASE PRINT CLEARLY**

Date of Application:  New Application  
 Update of Previous Application

Last Name:	First Name:	MI:	Date of Birth:	Gender:
Street Address:	City:	Zip:	Primary Phone #:	Alternate Phone #:
Mailing Address (If different):	City:	Zip:	Email Address (optional):	

**For the Hearing Impaired:** Do you use sign language:  Yes  No TTD / TTY #:

Name of Subdivision, Mobile Home Park, Apartment Building, etc.: Primary Language:

Living Situation (check one):  Live Alone  With Spouse / partner  With Children  With Parents  Other (Explain)

## Medical Information (Check those that apply to your medical condition.)

- |   |   |
|---|---|
| <input type="checkbox"/> Hearing Impaired               | <input type="checkbox"/> G-tube Feeders   |
| <input type="checkbox"/> Asthma, Emphysema, or COPD     | <input type="checkbox"/> Insulin Dependent  |
| <input type="checkbox"/> Visually Impaired              | <input type="checkbox"/> I.V. Medication  |
| <input type="checkbox"/> Seizures                       | <input type="checkbox"/> Walker   |
| <input type="checkbox"/> Speech Impaired                | <input type="checkbox"/> Incontinence Supplies  |
| <input type="checkbox"/> Memory Impaired                | <input type="checkbox"/> Refrigeration for Medication   |
| <i>(Specify condition):</i>                             | <input type="checkbox"/> Special Dietary Needs (Explain)  |
| <input type="checkbox"/> Developmentally Disabled       | <input type="checkbox"/> Portable Oxygen Machine  |
| <input type="checkbox"/> Mental Health Condition        | <input type="checkbox"/> Oxygen Concentrator or Ventilator  |
| <input type="checkbox"/> Ongoing contagious condition   | <input type="checkbox"/> Continuous   |
| <i>(Specify condition):</i>                             | <input type="checkbox"/> Intermittent   |
| <input type="checkbox"/> Bedridden                      | <input type="checkbox"/> Other (Explain)  |
| <input type="checkbox"/> Wheelchair Bound               |   |
| <input type="checkbox"/> Ostomy Care                    |   |
| <input type="checkbox"/> Weight in excess of 400 pounds | <i>*If you require a special diet and must go to a shelter be prepared - pack and bring with you the appropriate foods.</i> |

Any other required or life-sustaining equipment or medication:

**Medication Management:** You are strongly encouraged to complete a "Vial of Life" form listing all medications. If the form is not attached, please contact the local American Red Cross at 258-3888 for more information.

**Emergency Contact Information****In-state Emergency Contact**

Last Name	First Name	Relationship	Phone

**Out-of-state Emergency Contact**

Last Name	First Name	Relationship	Phone

**Medical Provider Information (Fill in all that apply)**

Physician Name:	Phone:

Pharmacy Name:	Phone:

Home Health Care Agency Name (or personal caregiver)	Phone:

Respiratory Equipment Provider (if applicable)	Phone:

<b>Shelter Information</b>	<b>Pet Information*</b>
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Can you, a family member or friend provide you with transportation to a shelter in an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have pets that would require special attention if you were asked to evacuate your home? If so indicate the number of: <input type="checkbox"/> dogs <input type="checkbox"/> service animal <input type="checkbox"/> cats <input type="checkbox"/> other (Describe other) _____
If you need assistance with transportation, check one of the following: <input type="checkbox"/> Automobile <input type="checkbox"/> Van with wheelchair lift <input type="checkbox"/> Bus <input type="checkbox"/> Medical transport required	

*\* Individuals are responsible for caring for the needs of an assistance animal, including bringing food and other essential needs to the shelter. Service animals are allowed in shelters but must provide proof of current rabies vaccine. Pets may not be able to accompany you to the shelter.*

**Emergency Planning**

In case of an emergency, do you plan to? (Place an (x) for the one that applies)

- Stay with family or others
- Stay at home
- Evacuate to an appropriate facility, independently
- Evacuate to an appropriate facility with caregiver

**Authorization Information**

By signing/submitting this form, I / legal guardian agree that my name be added to the Buncombe County Special Needs Registry. In the event of an emergency I hereby authorize the exchange of information between Buncombe County Emergency Services and the individuals and agencies listed on this form. I grant emergency responders permission to enter my home following an emergency event or disaster situation, if necessary, to assure my safety and welfare.

Applicant Signature	Date
X	

Authorized Guardian Signature	Date
X	

**Return Completed Forms to:** Attn. Special Needs, Emergency Services of Buncombe County  
60 Court Plaza, Asheville, NC 28801-3561  
Do you have questions regarding this form? Contact Buncombe County Emergency Management – 255-5087.