

**Albany County Sheriff's Office**  
Community and Emergency Services  
58 Verda Avenue  
P.O. Box A  
Clarksville, NY 12041  
Phone: (518) 720-8030 \* Fax: (518) 720-8031

**Evacuation Functional Needs 911 Registry Application**

Last	First	Middle Initial		
Address	Apt.#	City	State	Zip Code
Home Phone /TTY	Cell Phone	Email		

Sex:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Social Security # (optional): \_\_\_\_\_

Number of relatives living with you who will accompany you to a shelter if need be: \_\_\_\_\_

Residence Type:  Private Home  Apartment/Condo  Mobile Home  High-rise  
 Group Home  Retirement Home  Duplex  Dorm

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

Yearly resident?  Yes  No If no, from \_\_\_\_\_ to \_\_\_\_\_

Do you have pets?  Yes  No

Do you have arrangements for them in an emergency?  Yes  No

*Please be advised that pets may NOT accompany you to a shelter unless they are service animals.*

**Evacuation Information: PLEASE GIVE NAME AND PHONE NUMBER BELOW OF SOMEONE WE MAY CALL IF WE ARE UNABLE TO REACH YOU DIRECTLY:**

Will you require evacuation assistance?  Yes  No

Do you:  Care for yourself **or**  Regularly have assistance from a caregiver

Name of Caregiver: \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Transportation** (check all that apply)

- I will provide my own transportation  I can get to a bus pickup point
- I am ambulatory,  with assistance  I Need a wheelchair lift equipped vehicle
- I can transfer from a wheelchair to a seat  I am bedridden and require stretcher transport

**Is Your Disability:**  Temporary **or**  Permanent

If temporary, please give a medical release date: \_\_\_\_\_

Note: unless you notify registry personnel, you will be deleted from registry as of the above date.

**Type of Disability** (check all that apply)

- None  Hearing Impaired  require a translator, If so specify: \_\_\_\_\_
- Blind  I have a hearing/seeing service animal which will accompany me
- Mental Disability  Bedridden  Other: \_\_\_\_\_

**Special Equipment** (check all that apply)

- Wheelchair dependent  collapsible  non collapsible  Walker/cane
- Electric Dependent  Portable Oxygen – Hours per day: \_\_\_\_\_ Litre Flow: \_\_\_\_\_
- Other (please describe): \_\_\_\_\_

(Over)

**Medications:**

- Self administered, shelf kept    Intravenous, self administered, shelf kept
- Intravenous, self administered, refrigeration required, please list: \_\_\_\_\_
- Non self administered medication required    No medicine
- Medicine Allergy**, if so what  
 medicine(s): \_\_\_\_\_

**What illness do you take medication for (check all that apply):**

- Heart problems    Blood pressure    Stroke    Diabetes    Breathing problems
- Back problems    Seizures/convulsions    contagious diseases    Dialysis, # weekly \_\_\_\_\_
- other (describe): \_\_\_\_\_

Do you require a special diet?  Yes  No If yes, what type? \_\_\_\_\_  
 Type of shelter requested:    Standard    Special Need

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

Do you have any other comments or suggestions that may assist us in your care during evacuation?  
 \_\_\_\_\_

I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I hereby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue.

I understand my participation in this registry is voluntary and all information maintained will be strictly confidential, used only for emergency purposes and hereby request registration in the Albany County Evacuation Functional Needs 911 Registry.

I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation.

The information contained herein is true and correct to the best of my knowledge. I understand that assistance will be provided only for the duration of emergency, and that alternative arrangements should be made in advance in case I am not able to return to my home.

I understand, based on the information I have provided that I may or may not be assigned to a special needs unit based on the criteria slated in the information I provided. I understand that I am responsible for assisting in the provision of any prescription medications, oxygen supplies, medical equipment, and dietary items I may require during the emergency.

Registrant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_ (if registrant is unable to sign)  
 Relationship to Registrant (if any): \_\_\_\_\_

**Please Mail form back to:** Albany County Sheriffs Office  
 Community and Emergency Services  
 58 Verda Ave, P.O. Box A  
 Clarksville, NY 12041  
 Attn: Linda Nash

*Please contact **Linda Nash (518) 720-8030** in the event any of the above information changes at any time, such as an address change, medical change, etc. You will be contacted by our office if we have any questions regarding your application, and periodically contacted to update our records.*

<p><b><u>Agency Use only:</u></b></p> <p>Date Registered: _____</p> <p>Updated: _____</p>
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