



Disaster Help Mobile

SPECIAL NEEDS EVACUATION REGISTRY



IT IS THE RESPONSIBILITY OF EVERYONE TO PROVIDE FOR THE SAFETY OF ONE'S OWN AND ONE'S FAMILY IN A DISASTER. THIS REGISTRY IS INTENDED FOR THOSE WHO HAVE **NO** RESOURCES TO EVACUATE ON THEIR OWN AND NEED ASSISTANCE GETTING TO A SHELTER.

- TRANSPORTATION WILL ONLY BE PROVIDED TO DESIGNATED COMMUNITY SHELTERS.
- AT THIS TIME, WE **CANNOT** PROVIDE TRANSPORTATION FOR PETS.
- ONLY THOSE INDIVIDUALS WHO MEET THE CRITERIA SET BY THE ALABAMA DEPARTMENT OF PUBLIC HEALTH AND WHO ARE ACCOMPANIED BY ONE CAREGIVER WILL BE ADMITTED TO A MEDICAL NEEDS SHELTER. ALL OTHERS WILL GO TO A GENERAL POPULATION SHELTER.
- ALL EVACUEES MUST COMPLY WITH THE REQUIREMENTS OF THE SHELTERS AS DETERMINED BY THE MOBILE COUNTY EMERGENCY MANAGEMENT AGENCY AND THE AMERICAN RED CROSS.
- THIS REGISTRY IS FOR TRANSPORTATION ONLY. ENROLLMENT DOES NOT REGISTER YOU FOR THE MEDICAL NEEDS SHELTER OR GUARANTEE A PLACE FOR YOU IN THAT FACILITY.

THIS PROGRAM IS DESIGNED FOR THOSE WHO HAVE SPECIAL PHYSICAL/MEDICAL NEEDS AND MAY REQUIRE GOVERNMENT EVACUATION/SHELTER ASSISTANCE IN THE EVENT OF AN EMERGENCY. THE PROGRAM REQUIRES YOU TO ENROLL ANNUALLY. THIS PROGRAM IS NOT FOR THOSE WHO HAVE OTHER MEANS TO EVACUATE.

NOTE: TRANSPORTATION IS **NOT** PROVIDED TO RESIDENTS OF NURSING HOMES OR ASSISTED LIVING FACILITIES. PLEASE DISCUSS WITH YOUR FACILITY STAFF THEIR PLANS FOR YOUR SAFETY IN AN EMERGENCY.

PLEASE COMPLETE AND RETURN TO:

VOLUNTEER MOBILE, Inc.
1050 GOVERNMENT STREET
MOBILE, AL 36604
OR FAX TO: (251) 433-4456

YOU MAY REGISTER ON-LINE AT WWW.DISASTERHELPMOBILE.COM

IF YOU HAVE ANY QUESTIONS OR WISH TO REGISTER BY PHONE YOU MAY CALL 251-433-4456,
MONDAY - FRIDAY, 8:30 AM - 4:30 PM

CLIENT INFORMATION:

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NAME OF SUBDIVISION, MOBILE HOME PARK, OR BUILDING: _____

CLOSEST INTERSECTION: _____

Do You Live In:

HOUSE

APARTMENT

MOBILE HOME

NURSING HOME

ASSISTED LIVING

OTHER: _____

TRANSPORTATION IS NOT PROVIDED TO RESIDENTS OF NURSING HOMES OR ASSISTED LIVING FACILITIES. PLEASE DISCUSS WITH STAFF AT YOUR NURSING HOME OR ASSISTED LIVING FACILITY ABOUT THEIR PLANS FOR YOUR SAFETY IN AN EMERGENCY.

To ASSIST IN LOCATING YOU IN THE EVENT OF A DISASTER PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF SUBDIVISION, MOBILE HOME PARK AND LOT #, OR APARTMENT BUILDING: _____

CLOSEST INTERSECTION: _____

LIVING SITUATION:

LIVE ALONE

WITH SPOUSE

WITH CHILDREN

OTHER: _____

DO YOU RECEIVE HOME HEALTH CARE: YES NO

IF SO, PLEASE SELECT THE AGENCY:

ALACARE HOME HEALTH & HOSPICE

AMEDISYS HOME HEALTH OF MOBILE

GENTIVA HEALTH SERVICES

INFIRMARY HOMECARE OF MOBILE

SAAD'S HEALTH CARE SERVICES

SPRINGHILL HOME HEALTH AND HOSPICE

VANGUARD HOME HEALTH OF MOBILE

CONTACT INFORMATION:

HOME PHONE: _____

CELL PHONE: _____

DO YOU REQUIRE THE USE OF TDD? (TELECOMMUNICATIONS DEVICE FOR THE DEAF) YES NO

E-MAIL ADDRESS: _____

MARITAL STATUS:

SINGLE

MARRIED

DIVORCED

SEPERATED

WIDOWED

OTHER: _____

SPOUSE'S NAME: _____

NUMBER OF PEOPLE LIVING IN HOME: _____

LANGUAGE SPOKEN IN HOME:

- ENGLISH
- SPANISH
- FRENCH
- LAOTIAN
- CAMBODIAN

- VIETNAMESE
- GERMAN
- AMERICAN SIGN LANGUAGE
- OTHER: _____

WHEN IS THE BEST TIME TO CONTACT YOU?

- 7:00 AM – 3:00 PM
- 3:00 – 11:00 PM
- ANYTIME
- NEVER

EVACUATION PLAN INFORMATION:

IF YOU ARE LEAVING DUE TO AN EMERGENCY/DISASTER, DO YOU:

- HAVE A RELIABLE CAR
- HAVE SOMEONE TO RIDE WITH
- NEED TRANSPORTATION
- GO TO A PICK-UP STATION ON YOUR OWN

DO YOU HAVE A SERVICE ANIMAL (SEEING EYE DOG)? YES NO

SPECIAL NEEDS INFORMATION: PLEASE CHECK ALL THAT APPLY

- SPEECH IMPAIRMENT
- HEARING IMPAIRMENT (DEAF OR HARD OF HEARING)
- SIGHT IMPAIRMENT (BLIND OR VISUALLY IMPAIRED)
- MEMORY LOSS/MENTAL IMPAIRMENT
- TOTALLY BEDRIDDEN
- FULL-TIME (24/7) SKILLED NURSING CARE REQUIRED

MEDICAL NEED INFORMATION:

(ONLY INDIVIDUALS WITH ONE OR MORE OF THESE IS ALLOWED AT THE MEDICAL NEEDS SHELTER. ALL EVACUEES WHO ENTER THE MEDICAL NEEDS SHELTER MUST BRING THEIR OWN EQUIPMENT, SUPPLIES, MEDICATIONS, AND A CAREGIVER WHO WILL REMAIN AT THE SHELTER WITH THE PATIENT. DUE TO LIMITED SPACE, ONLY ONE PERSON MAY ACCOMPANY THE MEDICAL NEEDS EVACUEE.)

PLEASE CHECK ALL THAT APPLY TO YOU:

- PORTABLE VENTILATOR
- STABLE OXYGEN, NEBULIZER, OR SLEEP APNEA TREATMENTS
- FOLEY/SUPRA-PUBIC CATHETER
- FREQUENTLY INCONTINENT (URINARY/ BOWEL)
- OSTOMIES
- MILD DEMENTIA: NON-ABUSIVE OR WANDERING BEHAVIOR
- MENTAL ILLNESS WITH NONVIOLENT BEHAVIOR
- PERITONEAL DIALYSIS – HOME-MANAGED, SELF-ADMINISTERED OR FAMILY ADMINISTERED*
- IV TREATMENTS– HOME-MANAGED, SELF-ADMINISTERED OR FAMILY ADMINISTERED*

*CAREGIVER WHO ADMINISTERS TREATMENT MUST ACCOMPANY PATIENT

BIRTHDATE: _____ HEIGHT: _____ WEIGHT: _____

WHAT PORTABLE EQUIPMENT WILL YOU BRING WITH YOU TO THE SHELTER? (PLEASE CHECK ALL THAT APPLY)

- IV POLE
- PORTABLE VENTILATOR
- OXYGEN CONCENTRATOR
- OXYGEN TANK
- DIALYSIS MACHINE
- SUCTION MACHINE
- OTHER _____

WHAT WILL YOU BRING FOR MOBILITY?

- MANUAL WHEELCHAIR
- ELECTRIC WHEELCHAIR
- WALKER OF CANE
- SERVICE ANIMAL (SEEING EYE DOG)
- NEED ASSISTANCE TO AMBULATE
- OTHER PLEASE SPECIFY: _____

IF YOU ARE COMPLETING THIS INFORMATION FOR SOMEONE ELSE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME: _____

TITLE: _____ AGENCY: _____

PHONE: _____ E-MAIL: _____

RELATIONSHIP TO REGISTRANT: _____

THANK YOU FOR COMPLETING THE SPECIAL NEEDS EVACUATION REGISTRY. ALL INFORMATION PROVIDED WILL BE USED EXCLUSIVELY FOR ASSISTING YOU WITH EVACUATING IN CASE OF A DECLARED EMERGENCY OR DISASTER IN WHICH RESIDENTS ARE ASKED TO LEAVE THEIR HOMES FOR SAFETY REASONS.

PRIOR TO EVACUATING, YOU WILL RECEIVE A CALL VERIFYING YOUR NEED TO MOVE TO A SHELTER. ONLY LEAVE WITH INDIVIDUALS YOU KNOW OR WHO HAVE OFFICIAL CREDENTIALS TO TRANSPORT YOU. FOR MORE INFORMATION, CALL VOLUNTEER MOBILE AT (251) 433-4456.

DUE TO TIME AND LIMITED RESOURCES TO SAFELY EVACUATE PEOPLE WITH SPECIAL NEEDS, THE EVACUATION PROCESS MAY BE EXECUTED WELL IN ADVANCE OF AN IMPENDING DISASTER. YOU MUST BE READY TO EVACUATE WHEN TOLD TO DO SO BY EMERGENCY OFFICIALS! THE MOBILE COUNTY SPECIAL NEEDS REGISTRY IN NO WAY REPLACES THE RESPONSIBILITY OF INDIVIDUALS TO HAVE THEIR OWN EMERGENCY PLAN.

VOLUNTARY SUBMISSION NOTICE:

I AM SUBMITTING THIS INFORMATION VOLUNTARILY. I GIVE VOLUNTEER MOBILE, MOBILE COUNTY EMERGENCY MANAGEMENT AGENCY AND THE MOBILE COUNTY HEALTH DEPARTMENT AUTHORIZATION TO MAINTAIN AND SHARE THIS CONFIDENTIAL INFORMATION WITH LOCAL SUPPORT AGENCIES FOR USE ONLY IN THE EVENT OF AN EMERGENCY. DURING SUCH EMERGENCY, I AM GIVING LOCAL EMERGENCY PERSONNEL PERMISSION TO ENTER MY HOME, IF NECESSARY, TO ASSURE MY SAFETY AND WELFARE.

I HAVE READ AND UNDERSTOOD THE **VOLUNTARY SUBMISSION NOTICE**.

SIGNATURE: _____ . **DATE** _____

Please indicate if this is: New Application Update

For Office Use Only:

Notes:

Entered by: _____ Date entered: _____