North Carolina Department of Crime Control and Public Safety
Division of Emergency Management

Beverly Eaves Perdue, Governor
Reuben F. Young, Secretary

H. Douglas Hoell, Jr., Director

January 25, 2010

My Fellow North Carolinians:

The 2000 US Census Bureau reports an estimated 1.5 million of North Carolina's residents have some type of disability.

The 2009 Session of the North Carolina General Assembly authorized the North Carolina Division of Emergency Management to develop a voluntary special needs registry for use by counties and municipalities. By participating in this registry, you can improve your safety. We believe that the registry will assist government officials in special needs planning at both the local and state level.

We are excited about the opportunity to extend a chance for our residents to improve their personal preparedness. Please register if you require additional assistance during a time of disaster.

Please note that participation in this registry is strictly voluntary and records are kept confidential. A copy of your records may be provided to the Emergency Services providers for your county.

To register, please complete the information on the attached **Special Medical Needs Registry Application** as well as the **Conditions and Authorization to Release Information, Including Protected Health Information** form and submit it to your county's Special Needs Registry Project Manager.

Thank you for your partnership in making North Carolina a safer place.

Sincerely,

H. Douglas Hoell, Jr.
Director, NC Emergency Management

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Raleigh, NC 27699-4713
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www.NCCrimeControl.org

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CONDITIONS AND AUTHORIZATION TO RELEASE INFORMATION, INCLUDING PROTECTED HEALTH INFORMATION

Please read and initial each of the following:

_____ (initial) I hereby request that the information I have provided be listed in the State Special 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.

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

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

_____ (initial) I grant permission to emergency medical providers, transportation providers and 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.

_____ (initial) I understand that while registering this information may help emergency 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.

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

_____ (initial) I understand that I am responsible for making my own emergency preparations. 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.

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

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

_____ (initial) I understand that it is my responsibility to update the information I have provided 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 _____ 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: _____

North Carolina Emergency Management
Special Medical Needs Registry Application

Registrant Information

Last Name | First Name | Middle | Sex ○ Male ○ Female | Weight

Street | City | Zip | Primary Phone

Mailing Address (if different) | City | Zip | Primary Phone | Alternate Phone

Name of Subdivision, Mobile Home Park, Apartment Bldg | Language

Ex. Sign Language, Spanish, French, Italian, etc...

Living Situation

○ Live Alone ○ With Spouse/Significant Other ○ With Children ○ With Parents ○ Other

Medical History

- ☐ Allergies
- ☐ Asthma/Emphysema/COPD
- ☐ Bedridden
- ☐ Developmentally Disabled
- ☐ G-tube Feeders
- ☐ Hearing Impaired
- ☐ Insulin Dependent
- ☐ IV Medication
- ☐ Medications *(Explain below)*
- ☐ Memory Impaired *(Explain below)*
- ☐ Mental Health Condition
- ☐ Ostomy Care
- ☐ Oxygen Concentrator or Ventilator
  - ☐ Continuous
  - ☐ Intermittent
- ☐ Physically Disabled
- ☐ Portable Oxygen Machine
- ☐ Refrigeration for Medication
- ☐ Required or Life-Sustaining Equipment
- ☐ Seizures
- ☐ Special Dietary Needs
- ☐ Speech Impaired
- ☐ Suction Machine
- ☐ Vision Impaired
- ☐ Walker
- ☐ Wheelchair Bound
- ☐ Other *(Explain below)*

Explain any that have been checked above. List all known diagnoses, medications, etc.

Disaster Plan

- ☐ Stay with a friend
- ☐ Stay at home
- ☐ Evacuate to a shelter
- ☐ Require transportation to a shelter
  - Type of transportation required | *Ex. Automobile, Ambulance or Van with wheelchair lift*
- ☐ Will bring a service animal or pet to the shelter
- ☐ Other, Explain

Emergency Contact Information

Emergency Contact | Work Phone | Home Phone | Cell Phone

Medical Provider Information

Physician Name | Phone

Pharmacy Name | Phone

Home Health Care Agency (or personal caregiver) | Phone

Respiratory Equipment Provider (if applicable) | Phone