

INDIANA BOROUGH EMERGENCY MANAGEMENT

PEOPLE WITH SPECIAL CARE NEEDS VOLUNTARY REGISTRATION

This information is being compiled by Indiana Borough to assist residents with special care needs in an emergency

Name _____ Age _____ Weight _____

Physical Address _____

Town _____ Zip _____ Phone _____

TDD/TDY (for hearing impaired) Yes No

Mailing Address (if different from above) _____

Primary Language _____

Person to Contact in an Emergency _____

Home Phone _____ Work Phone _____ Cell Phone _____

Medical Information

(To be used for Transportation and Sheltering Purposes)

Check applicable medical conditions:

- Can walk unassisted
- Walk with: Walker Cane
- Use Wheelchair
- Am Bedridden
- Hearing-impaired
- Legally Blind
- Speech-impaired
- Contagious Disease
- Specify other limitations _____
- _____

Check any of the following you require:

- Respirator Dialysis
- Insulin IV Fluids
- Feeding Tube Suction Unit
- Other Special Medications
- Special Diet
- If yes, what type? _____
- I require a 24-hr caregiver
- I require Oxygen
- I have an oxygen machine
- I have a portable oxygen tank

Primary Physician _____ Phone _____

Home Health Care Provider _____ Phone _____

Pharmacist _____ Phone _____

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Evacuation Requirements

If I have to evacuate I will go to: Family Friend Shelter

Name _____ Phone _____

Can you get to an evacuation shelter without outside help? Yes No

Will a caregiver accompany you to the evacuation shelter? Yes No

If no, check the appropriate transportation type needed:

Standard vehicle (car, bus) Wheelchair Capable Ambulance

Pets

Please note: Pets are not permitted in human shelters

Do you have pets? Yes No

Type: Cat Dog Bird Other

Do you have arrangements for your pet(s) to be cared for by someone else in the event you need to evacuate? Yes No

I certify the above information is correct. I hereby grant permission to Indiana Borough Emergency Management to release this information based on information provided on the HIPAA Compliance Disclosure attached..

Signed _____ Date _____

RETURN FORM TO: **Indiana Borough Emergency Management**
Special Needs Registry
80 North 8th Street
Indiana, Pa. 15701

-----Do Not Write Below This Line-----

Indiana Borough Emergency Management
Special Needs Registry
80 North 8th Street
Indiana, Pa. 15701

For Emergency Management Use Only
EOP Update Date _____
Registration Date _____
Revision Date _____

Indiana Borough Department of Emergency Management
Authorization for Use or Disclosure of Personal Information

1. I authorize the Indiana Borough Department of Emergency Management to use/disclose individual information as described below from the records of:

Name:

Address_

2. Reason for disclosure: _

Indiana Borough Department of Emergency Management is collecting personal information for the purposes of emergency planning for special needs individuals. This information will be used to identify special needs individuals in the event of emergency or disaster and during emergency planning activities so that appropriate resources can be deployed and utilized efficiently. The Gathering and use of this information is an attempt to plan for special needs requirements at emergency shelters, to provide transportation and other emergency related accommodations. Your information may be shared with emergency response agencies, Fire, Police, EMS, 911, Emergency Operations Centers, Red Cross, Hospitals, Shelter personnel or other agencies providing emergency support during an emergency or disaster situation.

3. I understand that:

- a. This authorization may be revoked at any time by writing to the individual/organization identified in section 1 except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- b. The Indiana Borough Department of Emergency Management will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
- c. Information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to re-disclosure by the individual/organization identified in section A.2 below and is no longer protected by federal privacy regulations.
- d. The Department, its programs, services, employees, officers, Affiliates, mutual aid agencies and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
- e. I may refuse to sign this authorization.

PART A-General Information

- A.1 Information to be disclosed will include any information voluntarily provided to the Indiana Borough Department of Emergency Management on the Special Needs Registry Form
- A.2 This information is to be disclosed to: Indiana Borough Department of Emergency Management, 80 North 8th Street, Indiana, Pa. 15701 and any affiliated Emergency Services Agency by mutual aid agreement, Local Emergency Planning Committees, Fire, Police, EMS, 911, Emergency Operations Centers, Red Cross, Hospitals, Shelter personnel or other agencies providing emergency support during an emergency or disaster situation.
- A.3 This authorization will not expire, unless revoked by you in writing.

PART B-Special Categories of Medical Information

B.1 Drug and Alcohol Information

If my medical record includes drug and alcohol information, I want to send that information to the individual/organization identified in Part A of this form.

Yes ___ No or Not Applicable

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B.2 Mental Health Information

If my medical record includes mental health information, I want to send that information to the Indiana Borough Department of Emergency Management or identified in Part A of this form.

Yes No or Not Applicable

B.3 HIV/AIDS Information

If my medical record includes HIV/Aids information, I want to send that information to the individual/organization identified in Part A of this form.

Yes ___ No or Not Applicable

This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

* * * * *

Signature of Individual or Personal Representative

Date

If Personal Representative, State relationship

Signature of Witness
(Necessary for release of mental health and Drug
And Alcohol Information).

Date

Second Witness, if individual is physically unable to sign

Date