TOWN OF EAST HAMPTON

Department of Human Services
128 Springs Fireplace Road
East Hampton, NY 11937

Diane Patrizio, Director

Telephone: (631) 329-6939
Fax: (631) 329-6693

EMERGENCY ASSISTANCE FOR

EAST HAMPTON TOWN RESIDENTS WITH

SPECIAL NEEDS

The Town of East Hampton Department of Human Services has developed a computerized registry of all town residents with *SPECIAL NEEDS* who need to receive evacuation and shelter *assistance* during natural disasters like hurricanes or severe flooding.

This is a free and voluntary registration. The information you provide will be confidential, in accordance with State law. It will be used by emergency personnel only to assure your safe and timely evacuation. Please fill out the questionnaire and return it to:

Diane Patrizio, Director
Department of Human Services
128 Springs Fireplace Road
East Hampton, N.Y. 11937

Please note: For those Senior Citizens **who may not** have special needs but would like to be on our "Reassurance Calling List", please fill out attached form **up to** "Phone Call Only" section and return to address above.

For more information or additional questionnaires please call 631-329-6939.

(Note to Agency's: Please add your agency's contact person and fax number at the bottom of the registry form.)

TOWN OF EAST HAMPTON

EMERGENCY EVACUATION REGISTRY 2022/23

Name______________________________________

D.O.B._____/_____/_____Sex: M______F ______

Street Address_____________________________

Nearest Cross St.___________________________

Mailing Address____________________________

Fire District_______________________________

House No._______________Apt. No.____________

Telephone No.______________________________

Primary Language___________________________

Single Family Home_________Mobile Home_____

Apartment/Condo__________Floor___________

Seasonal Res?_________When?______________

I need a phone call only: Yes __________

Will you be accompanied to the shelter?

Yes_____By Whom________________No _______

Do you live alone? Yes_________No __________

If"No", Family?_____Caretaker?_______Other____

Number of People____________________________

Next of kin or Guardian's Name & Phone #:

____

Are you receiving Home Health care (Y/N)_______

Name & Phone Number of Agency:

____

Disability/Medical Condition:

Legally Blind__________ Deaf ______________

Hard of Hearing_______Speech Impaired______

Mobility Impaired________Diabetic___________

Hypertension_______Other__________________

Are you confined to: Bed?________Crutches_____

Wheelchair____________Walker/Cane_________

Other_______________________________________

If you use a life support system, complete:

Instructions/ Portable? Hours/Days__________

Oxygen_____________________________________

Respirator__________________________________

Electrical___________________________________

Dialysis_____________________________________

Other_______________________________________

Special Transportation Needs?

Lift Gate Vehicle__________Ambulance_________

Barriers to entering house_______Pets __________

Do you have a special diet? Yes_______No_______

If "Yes", what type?_________________________

Are you on medication?________________________

Do your medications need refrigeration? Y / N

(If yes, please list on back of form.)

Signature____Date:______________________________

FOR HUMAN SERVICE USE ONLY:

Filed by:______________________________________ Phone #:____________________________