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:

Lisa A. Charde
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 call 329-6939 or the N.Y. State Relay # 1-800-662-1220.

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

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TOWN OF EAST HAMPTON

EMERGENCY EVACUATION REGISTRY 2014

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 _____Speach 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/Day_____

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?_____

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

Do your medications need refrigeration? Y / N

Signature _____ Date:_____

FOR OFFICIAL USE ONLY:

Filed by: Agency Name:_____ Contact:_____

Phone# _____ Fax# _____