



TOWN OF EAST HAMPTON

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

Diane Patrizio, Director

Telephone: (631) 329-6939

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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

2021

Name _____

Disability/Medical Condition:

D.O.B. ____/____/____ Sex: M ____ F ____

Legally Blind _____ Deaf _____

Street Address _____

Hard of Hearing _____ Speech Impaired _____

Nearest Cross St. _____

Mobility Impaired _____ Diabetic _____

Mailing Address _____

Hypertension _____ Other _____

Fire District _____

Are you confined to: Bed? _____ Crutches _____

House No. _____ Apt. No. _____

Wheelchair _____ Walker/Cane _____

Telephone No. _____

Other _____

Primary Language _____

If you use a life support system, complete:

Single Family Home _____ Mobile Home _____

Instructions/ Portable? _____ Hours/Days _____

Apartment/Condo _____ Floor _____

Oxygen _____

Seasonal Res? _____ When? _____

Respirator _____

I need a phone call only: Yes _____

Electrical _____

Will you be accompanied to the shelter?

Dialysis _____

Yes _____ By Whom _____ No _____

Other _____

Do you live alone? Yes _____ No _____

Special Transportation Needs?

If "No", Family? _____ Caretaker? _____ Other _____

Lift Gate Vehicle _____ Ambulance _____

Number of People _____

Barriers to entering house _____ Pets _____

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

Do you have a special diet? Yes _____ No _____

If "Yes", what type? _____

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

Are you on medication? _____

Name & Phone Number of Agency:

Do your medications need refrigeration? Y / N

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

Signature _____ Date: _____

FOR OFFICIAL USE ONLY:

Filed by: Agency Name: _____ Contact: _____

Phone# _____ Fax# _____