Iredell County Special Medical Needs Registry

Dear Iredell County Resident,

The 2010 U.S Census Bureau says, 8.9% of North Carolinians under the age of 65 have some type of disability. In order to assist residents of Iredell County of all ages, a special medical needs registry has been developed to help Emergency Management and other first responder agencies know about residents that may have difficulties during a disaster or significant event. You may sign up for the special medical needs registry if you or someone you love needs additional assistance during times of emergencies or disasters.

The Iredell County Special Medical Needs Registry gives key information to emergency workers in the event of a 911 call and/or during a disaster such as a hurricane, flood, winter storm, power outage, disease outbreak or nuclear event, etc. **Persons on the registry are volunteering for the list and have the choice to agree to, or say no to, assistance.** Filling out this form does not guarantee the signed up person will receive immediate or special aid in an emergency or disaster. People should always have their own emergency plan in place. This registry allows Emergency Service Providers (emergency management, fire departments, law enforcement, Public Health, etc.) to share this information with one another to help with your recovery. All records are kept confidential.

Eligible people for the list must live in Iredell County AND have at least one of the following:

- Have to have help with daily living actions (dressing, bathing, toileting, etc.)
- Have need of medical observation or aid
- Have a constant or lasting, or easily spread sickness (Tuberculosis, Dementia, etc.)
- Disability and/or homebound
- DO NOT live in a long term facility (Nursing Home, Assisted Living, or Care Home)

Step 1: To register, please fill out and sign these papers:

- Conditions and Authorizations to Release Information, including Protected Health Information form
- Special Medical Needs Registry Application

Step 2: Mail the completed forms to:

Iredell County Emergency Management
P.O. Box 788
Statesville, NC 28687

Step 3: Update your information every year or sooner if it changes with Iredell County Emergency Management, 704-878-5353.

You will receive a phone call or mailing at least every other year to update your information. If your health condition or personal information changes before the scheduled update, please contact Iredell County Emergency Management at 704-878-5353 to change your information in the registry. Your information will be checked at least every other year. If Iredell County Emergency Management cannot reach you after three attempts during the update, your information will be deleted from the registry.

For additional information you can call the Iredell County Emergency Management office at 704-878-5353, Monday-Friday 8am-5pm. Thank you for helping us to assist you in disaster situations.

Respectfully,

Kent Greene, Director
Iredell County Emergency Management

*Enclosed

CONDITIONS AND AUTHORIZATION TO RELEASE INFORMATION, INCLUDING PROTECTED HEALTH INFORMATION

Please read and initial each of the following:

_____I hereby request that the information I have provided be listed in the Iredell County (initial) Special Medical Needs Registry and the North Carolina State Special Needs Registry. I understand that submitting the information to participate in the Iredell County Special Medical Needs Registry and the North Carolina State Special Needs Registry does not guarantee that I will be included in the Registries.

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

_____I understand that at any time I may ask that my name be removed from the Registries by (initial) sending a written request to Iredell County Emergency Management and the NC Division of Emergency Management.

_____I grant permission to emergency medical providers, transportation providers and other (initial) 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.

_____I understand that while registering this information may help emergency responders to (initial) 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.

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

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

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

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

_____I understand that it is my responsibility to update the information I have provided at least
(initial) once a year or when my information changes, whichever occurs first.

_____I grant permission to medical providers, transportation agencies, and others as necessary
(initial) 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 evacuation,
(initial) 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 evacuation or
(initial) 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, if I have
(initial) 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 have
(initial) another opportunity to obtain this service.

_____I understand that based on this information and the data I have provided; Iredell County
(initial) Emergency Management and the NC 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 or
(initial) power failures.

I understand that completing this form and including my information in the Iredell County Special Medical Needs Registry and 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, Iredell County Emergency Management, 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 Iredell County Special Medical Needs Registry and 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 Iredell County Special Medical Needs Registry and 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 Iredell County Special Medical Needs Registry and 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 Iredell County Special Medical Needs Registry and 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 Iredell 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 Registries 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 Iredell County 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 this out is not the patient please complete the following 2 lines:

Name: _____ ***Phone:*** _____

Relationship/Agency: _____

REQUIRED Personal Enrollment Data:

(One Person Per Form, Please Print)

Date of Application:_____

New Application or **Update of Existing Application**
(Circle one)

Last Name: _____ First Name:_____

Middle: _____ Sex: ☐ M ☐ F Weight:_____

Street Address: _____ Apt.: _____

City: _____ Zip Code:_____

Mailing Address: _____
(if different from above)

City: _____ Zip Code:_____

Primary phone: (____) ____-_____

Alternate phone number: (____) ____-_____

Primary Language: _____

Name of Subdivision, Mobile Home Park, Apartment Building:

_____

Living Situation:	☐	Living Alone	☐	Living with Parents	☐	Living with Spouse/Significant Other
☐	Living with Children	☐ Other *(please explain below)*				

Medical History (please check all that apply)					
☐	Allergies	☐	Memory Impaired *(explain below)*	☐	Seizures
☐	Asthma/Emphysema (COPD)	☐	Mental Health Condition *(explain below)*	☐	Special Dietary Needs *(explain below)*
☐	Bedridden	☐	Ostomy Care	☐	Speech Impaired
☐	Developmentally Disabled	☐	Oxygen Concentrator or Ventilator	☐	Suction Machine
☐	G-Tube Feeder		☐ Continuous ☐ Intermittent	☐	Vision Impaired
☐	Insulin Dependent	☐	Physically Disabled	☐	Walker
☐	IV Medication	☐	Portable Oxygen Machine	☐	Wheelchair Bound
☐	Medications *(explain below)*	☐	Refrigeration for Medication(s)		
☐	Other *(explain below, use additional paper if necessary)*				

Iredell County Department of Social Services

Disaster Plan

If you require a special diet and must go to a shelter be prepared- pack and bring with you food you can eat and drink.

☐ Stay with a friend/family member	☐ Stay at home	☐ Evacuate to shelter
☐ Require transportation to a shelter *(please specify type of transportation below)*	☐ Will bring a service animal or pet to the shelter	
☐ Other *(please explain):*		

Emergency Contact Information

Emergency Contact Name:

_____

Home Phone:

(_____) _____-_____

Work Phone:

(_____) _____-_____

Cell Phone:

(_____) _____-_____

Medical Provider Information

Physician Name:

_____

Phone:

(_____) _____-_____

Pharmacy Name:

_____

Phone:

(_____) _____-_____

Home Health Agency (or personal caregiver):

_____

Phone:

(_____) _____-_____

Medical Equipment Provider:

_____

Phone:

(_____) _____-_____