2013 Special Needs Registry

Individuals are eligible to be registered with the Special needs Registry if they are frail, elderly, medically needy, and/or disabled and are not served in or by a residential facility program. Eligible clients are required to complete and sign the application as well as the HIPPAA disclosure of information and HIPPAA privacy Act forms before they will be placed on the registry.

Please print clearly

Do you have Medicare Y___N___#_____

Last Name_____First_____Middle Initial_____

Physical Address_____

Mailing Address (if different)_____City_____Zip_____

Do you plan to evacuate to a public shelter? _____Y_____N_____
Do you need Transportation? Terry, Gaines, Yoakum, Dawson or Lynn County you_____Y_____N____
Please circle which county you are living in.
(**If you answered *NO* to both of the above, you will not be registered and need only to sign the back of the form. If you answered *YES* to either or both please continue to complete the form front & back.)**
If you do not have a phone, you must list a neighbor's phone number that we may contact you.
Live in the country? Nearest Mile Marker_____Home phone #_____
Spanish Only Y_____N_____ Sex M_____F_____ Date of Birth_____ (mm/dd/yyyy)

If married: Name of Spouse_____ Is Spouse registered? Y_____N_____

Residence Type (Please Check One) Single Family Home/Duplex _____ Apartment_____
Mobile Home_____Multi-Family Home_____ Income Related Housing _____RV_____

Number of Pets in home: Dog_____Cat_____Other (Type and #) _____
(**NOTE:** Pets of the clients are eligible also, we just need the information at the time this forms is filled out**. Service animals are always allowed**).

Year round resident ___or a Seasonal Resident___If Seasonal, which months in County_____
Can you sit up and ride in a bus or van? ----------Y_____N_____
Do you need a wheelchair lift? ----------Y_____N_____
Do you require an ambulance for transportation----------Y_____N_____
(**If yes, you will be contacted by Emergency Medical Services to assess your condition**)
Are you receiving Home Health Care or Hospice----------Y_____N_____
If yes, Name of Agency_____Phone Number_____
If you have a required caregiver, please list their name and phone number
Name_____phone Number_____
Total number of people that will accompany you to a shelter? _____ (space is very limited so please limit to one caregiver and any dependent children.)
You must give a current name and phone number of a neighbor or friend that we may use for an alternate contact: This person must live in your area & be aware that they are listed as an alternate contact!!
Name_____Phone Number_____

**********************TO BE FILLED OUT BY REFERRING AGENCY**********************
Agency Name: _____
Location & Phone Number_____

New Client_____Udate Client Only_____Delete_____ (reason)_____