



# York County Special Needs



## Registration Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Revision: 02-2017

### Personal Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Male or Female (circle one)  
Municipality in which you are located: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

### Additional Information

Home: Own \_\_\_\_\_ Rent \_\_\_\_\_ Group Home \_\_\_\_\_ Foster Care \_\_\_\_\_ With Family \_\_\_\_\_  
Do you speak English? Yes \_\_\_\_\_ No \_\_\_\_\_ If NO, list your native language: \_\_\_\_\_  
Do you read English? Yes \_\_\_\_\_ No \_\_\_\_\_  
Pets that need evacuation? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type of pets? \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell: \_\_\_\_\_  
Relationship: \_\_\_\_\_

### Evacuation and Emergency Information

### **Check All That Apply:**

- |  |   |
|--|---|
| <input type="checkbox"/> Confined to bed   | <input type="checkbox"/> May not be able to evacuate without help due to a mental disability, mental retardation, Autism, Alzheimer's, or due to not being able to respond verbally (circle applicable) |
| <input type="checkbox"/> Confined to wheelchair or motorized scooter (circle applicable) | <input type="checkbox"/> Service animal   |
| <input type="checkbox"/> Require dialysis: how often? _____                              | <input type="checkbox"/> Sight Impairment   |
| <input type="checkbox"/> Require medical support equipment (oxygen, ventilator, other)   | <input type="checkbox"/> Hearing Impairment   |
| <input type="checkbox"/> Walk with walker, cane, or other walking aid                    |   |
| <input type="checkbox"/> Medical Devices (e.g. pacemaker, insulin pump) _____            |   |
| <input type="checkbox"/> Other (Please Explain) _____                                    |   |

Do you have a personal means of transportation, such as a car or truck, to evacuate in an emergency? ☒ Yes ☐ No

Do you have a radio, TV or internet-connected device (such as a computer or smartphone) from which you can receive emergency information and instructions? ☒ Yes ☐ No

*I have read and understood the information release on the back of this form.*

Registrant / Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return to: Dover Township EMA, 2480 W. Canal Rd., Dover, Pa 17315**

# Client Consent Form

## Privacy of Health Information / HIPAA Disclosures in Emergency Situations

HIPAA permits various agencies and public officials who are responding to a manmade or natural emergency to disclose needed information to public officials in a variety of ways. This allows emergency responders to communicate effectively in the face of an emergency. Covered entities may disclose protected health information, without the individuals authorization, to a public health authority acting as authorized by law in response to a man-made or natural emergency.

*See: 45 CFR 164.512 (b); 45 CFR 164.512 (j); 45 CFR 164.512 (f); 45 CFR 164.512 (k) (2); or judicial and administrative proceedings; 45 CFR 164.512 (e).*

### Client Consent

- ♦ I consent to having my information be shared with York County Human Services, York County Emergency Management, others involved in the York County Special Needs Registry, as well as local emergency responders and municipal officials.
- ♦ **Liability Notice:** Neither the County of York (or any of its elected officials, employees, agencies, or departments), York County Planning Commission, your local municipality, nor any of the individuals or entities involved in the accumulation of data, entry of data, or use of the data can assure the accuracy, completeness, or reliability of the information provided or the use of that information in an emergency situation. Under no circumstances shall the County of York nor the other entities as noted previously be liable to you, including claims of negligence, for any special, incidental, direct, indirect, punitive, or consequential damages.
- ♦ **Information Notice:** I agree that you may retain my information and use it for emergency planning and response, effective from the date of my signature and continuing until / if I submit a signed, dated notice to my local municipal office, to the attention of Emergency Management, requesting that they remove my information. I understand that my local municipality may remove my name from the Special Needs Registry service. I understand that I am also responsible for notifying my municipality if I change my address or health status.

Questions?

Contact: Dover Township EMA  
2480 W. Canal Rd  
Dover, Pa 17315  
[azarlenga@dovertownship.org](mailto:azarlenga@dovertownship.org)  
717-292-3634