

**Trumbull County Special Needs Registration Form**

**HIPAA Waiver must be signed and included with submission of registry form.**

**Questions or Comments: (330) 675-2730**

Date of Application
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**Personal Information**

Last Name	First Name	Middle Initial	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (include city, state and zip code)			Home Phone	Cellular Phone
Email			TTY/Video Phone	Alternate Phone
Living Situation <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> Other	Residence Type <input type="checkbox"/> Private Home <input type="checkbox"/> Apt./Condo <input type="checkbox"/> Mobile Home	Race/Ethnic Group <input type="checkbox"/> African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic		Language <input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> Korean <input type="checkbox"/> Tagalong <input type="checkbox"/> Chinese <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Vietnamese <input type="checkbox"/> English <input type="checkbox"/> Italian <input type="checkbox"/> Spanish

**Emergency Contacts**

Primary Emergency Contact	Relationship	Home Phone	Work Phone	Cellular Phone
Address (include city, state and zip code)		Email Address		
Secondary Emergency Contact	Relationship	Home Phone	Work Phone	Cellular Phone
Address (include city, state and zip code)		Email Address		

**Medical Information**

<input type="checkbox"/> Requires 24-hr Care <b>Requires Life-Sustaining Equipment</b> <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Dialysis <input type="checkbox"/> Suction <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other (Describe Below) <b>Requires Life-sustaining Medication</b> <input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Diabetes <input type="checkbox"/> Other (Describe Below) <b>Mobility Impairments</b> <input type="checkbox"/> Bedridden <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane	<b>Communication Impairments</b> <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Forgetful <b>Sight Impairments</b> <input type="checkbox"/> Blind <input type="checkbox"/> Other (Describe Below) <input type="checkbox"/> Cardiac History (Describe Below) <input type="checkbox"/> Respiratory History (Describe Below)
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Dependencies	Medications
Physical Conditions	Allergies
Medical Conditions	Other Medical Notes

**Medical Providers**

Oxygen Provider	Phone	Home Health Agency	Phone
Primary Physician	Phone	Pharmacy	Phone

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Special Needs Registration Form**

**MY PERSONAL DISASTER PLAN**

- I will have a caregiver.                      Caregiver Name \_\_\_\_\_  
Relationship \_\_\_\_\_                      Phone Number \_\_\_\_\_
  
- I will evacuate/shelter with family/friend.      Family/Friend Name \_\_\_\_\_  
Relationship \_\_\_\_\_                      Phone Number \_\_\_\_\_  
Address \_\_\_\_\_
  
- My transportation will be provided by \_\_\_\_\_
  
- I will have all necessary medications and equipment.
- I will have a list of current medications from my pharmacist.
- I will have a disaster supplies kit.

**MY PET'S DISASTER PLAN**

Do you have a pet? Yes \_\_\_ No\_\_\_                      If yes, list Type, Size/Weight \_\_\_\_\_

My Pet's Disaster Plan \_\_\_\_\_

Do you have a service animal? Yes \_\_\_ No\_\_\_

\*When bringing a service animal to a shelter, please have identification indicating your need for the animal.

**Information Release**

I certify that the above information is correct. I hereby grant permission to Trumbull County 911 to use this information for the following purposes ONLY: (1) to include my name and information in the Trumbull County Special Needs Registry; and/or (2) to give to emergency response agencies for assistance with evacuation or aid in the event of a disaster or emergency. This information is confidential.

SIGNATURE: \_\_\_\_\_                      DATE: \_\_\_\_\_

**GUARDIAN:** \_\_\_\_\_

**Report prepared by:**

Agency/Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please mail form to:**

Trumbull County 911 Dispatch Center  
Attn: Special Needs Registry  
911 Howland Wilson Rd. NE  
Warren, OH 44484

**For Office Use Only:**

Entered into TC911  
CAD  
(date) \_\_\_\_\_  
(initials) \_\_\_\_\_

**You may also email the form to:** erdivies@co.trumbull.oh.us

**It is your responsibility to verify your special needs information with the Trumbull County Special Needs Registry annually. Failure to do so may result in the distribution of outdated or unknown information to first responders.**

Citizens utilize the services of the Trumbull County Special Needs Registry at their own discretion. The Special Needs Registry, acting in good faith, is permitted to waive certain rules in order to provide temporary shelter or services during disasters and emergencies. Temporary sheltering facilities, and the Trumbull County Special Needs Registry aren't liable for providing care. A personal caregiver is required during the period of temporary placement.