UNION COUNTY
north carolina

Functional Needs Registry

Union County Human Services is responsible for maintaining a registry for residents in Union County who have access and functional needs. Individuals who have a disability that may impair their ability to seek safety during an emergency are asked to register. The registry serves as a database to use during emergency situations and the information provided will be used for emergency response purposes only.

Signing up for this registry is not a guarantee of service. If you have any questions, please call 704.296.4820.

General Information

Are you a resident of Union County?

☐ Yes ☐ No*

*If you are NOT a resident of Union County, you are not eligible to use this form. Please check with your county of residence for further information on functional needs registration.

First Name: _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **ZIP**:_____

Primary Phone: _____ **Alternate Phone:** _____

Email Address: _____

Age: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Additional Information

1. Do you have a service animal?

Service animals are defined as dogs or miniature horses that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, and reminding a person with mental illness to take prescribed medications. Service animals are working animals, not pets. The work or task they have been trained to provide must be directly related to the person's disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

☐ Yes ☐ No (***if "No," skip to question 2***)

If yes, what work, or task has the animal been trained to perform?

_____

If yes, what type of animal is the service animal?

_____

2. Do you have a full-time caregiver?

☐ Yes ☐ No ***(if "No," skip to question 3)***

If yes, will your caregiver evacuate shelter with you?

☐ Yes ☐ No*

Caregiver Contact Name: _____

Caregiver Phone: _____ **Alternate Phone:** _____

Caregiver Email Address: _____

3. Do you live alone?

☐ Yes **(if "Yes," skip to question 4)** ☐ No

If no, who do you live with?

☐ Family ☐ Caretaker

☐ Group Home ☐ Other: _____

4. Do you require electricity for life sustaining medical equipment?

☐ Yes ☐ No ***(if "No," skip to question 5)***

If yes, what type of medical equipment would you need in an emergency? Check all that apply:

☐ Ventilator

☐ Oxygen concentrators and/or nebulizers

☐ CPAP

☐ Infusions, intravenous equipment, and feeding equipment

☐ Suction pumps

☐ Dialysis machines

☐ Refrigerated medication, such as insulin

☐ Augmented and Alternative (AAC) Devices/Software

☐ Wound care management

☐ Other: _____

_____

5. Emergency Contact Information

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact Alternate Phone: _____

6. Mobility

Check all that apply:

☐ No mobility issues

☐ Able to walk with assistance

☐ Confined to bed

☐ Wheelchair/Mobility Vehicle

☐ Prosthesis

☐ Cane

☐ Walker

☐ Other: _____

_____

7. Assistance with Activities of Daily Living

Check all that apply:

☐ None

☐ Bathing

☐ Dressing

☐ Using the toilet

☐ Continence

☐ Eating

☐ Sitting/ Standing

☐ Other: _____

8. Transportation for Evacuation or to a Shelter

Check all that apply:

☐ No transportation needs

☐ Need transportation: can use standard vehicle

☐ Need transportation: require wheelchair accessible vehicle

☐ Need transportation: require a stretcher

☐ Other: _____

9. Sensory

Check all that apply:

☐ None

☐ Legally Blind

☐ Braille Needs

☐ Speech impairment

☐ Non-verbal

☐ Deaf

☐ Hard of Hearing

☐ Hearing aids/Assistive Technology

☐ Sign Language

☐ Difficulty understanding verbal instructions

☐ Other: _____

_____

10. Learning, Developmental and Mental

Check all that apply:

☐ None

☐ Alzheimer's

☐ Dementia

☐ Amnesia

☐ ADHD

☐ Brain Injury

☐ Learning Disability

☐ Autism

☐ Genetic Condition

☐ Behavioral

☐ Mental

☐ Other:_____

_____

_____

11. Medical

Check all that apply:

☐ None

☐ Insulin

☐ Oxygen

☐ Dialysis

☐ Feeding Tube

☐ Catheter

☐ Wound Care

☐ Life Support

☐ Seizure Disorder

☐ Obesity*

☐ IV Meds

☐ Joint Pain/ Stiffness

☐ Stoma or Ostomy

☐ Genetic Disability

☐ PICC/Central line

☐ CPAP

☐ Prosthesis

☐ Respiratory Therapy

☐ Physical Therapy

☐ Dysphagia (difficulty swallowing)

☐ Other: _____

If "Obesity" is marked, what is your weight (lbs.)?

_____

12. Pharmaceuticals

Check all that apply:

☐ None

☐ IV medications/infusions

☐ Medication that requires refrigeration

☐ Narcotics

☐Other: _____

I certify that the above information is correct. I understand that I am responsible for all expenses associated with medical evacuation and shelter at a hospital. I hereby grant permission to Union County to release this information to other emergency response agencies as needed during emergency situations and for planning purposes.

Date: _____

Printed Name: _____

Signature: _____

Please return this form to Jason Gurian, Emergency Preparedness Coordinator; Union County Human Services, 2330 Concord Avenue, Monroe, NC 28110