JEWISH TRADITION HOME CARE

PEOPLE WITH SPECIAL NEEDS
REGISTRATION FORM

☐ INITIAL
☐ CHANGE

PLEASE PRINT

Patient Last Name: ________________________ First Name: ________________ MI: ______ Speak English? ____ Yes ____ No

Street Address: ____ DOB: ___ / ___ / _____ Age: ___ Sex: ____

City: ____________________ Zip Code: ________ Home Phone: _____________ TDD/TDY: __Y __N SS#: ____-____-_____

Next of Kin Name: __________________________________ Home Phone: ______________ Relationship: _________________

Emergency Contact Name: __________________________ Home Phone: ______________ Relationship: _________________

Doctor's Name: ____ Phone: __________________________________

Pharmacy Name: ____ Phone: __________________________________

LIVING SITUATION: (Check All That Apply)	**IMPAIRMENT:** (Check All That Apply)	**DISASTER PLAN:**	**DIRECTIONS TO HOME:**
☐ Mobile Home/Trailer	☐ Mobility	☐ Staying at Home	FROM:
☐ Dependent on Electricity	☐ Memory	☐ To Any Shelter	______________________
☐ Emergency Alert Equipment	☐ Vision	☐ To Special Needs Shelter	______________________
☐ Life Sustaining Medications	☐ Hearing	☐ **Needs Evacuation Transport By:**	______________________
☐ No Alternate Housing	☐ Wheelchair	☐ stand vehicle	______________________
☐ No Emergency Heat	☐ Respirator Dependent	☐ ambulance	______________________
☐ No Telephone	☐ Speech	☐ lift gate	______________________
☐ Lives Alone	☐ Mental	☐ Other (family, hotel, hospital)	______________________
☐ Lives with Spouse	☐ Epilepsy	☐ Will Bring Caregiver to Shelter	______________________
☐ Lives with Spouse & Kids	☐ Anxiety/Depression	☐ Guide Dog	______________________
☐ Lives with Kids	☐ Cardiac History	☐ Vial/Packet of Life User	______________________
☐ Lives with Parents	☐ Bedridden	☐ Other: ____________________	______________________
☐ Lives with Other Relative	☐ Insulin Dependent	________________________	______________________
☐ Lives with Non-Relative	☐ Incontinent of Bowel/Bladder	**SPECIAL AREAS:**	______________________
☐ Live in Group Home	☐ Special Diet: ________	☐ Lives in River Flood Zone	______________________
☐ Other: __________________	____________________	☐ Lives in Hurricane Evac. Zone	______________________
________________________	☐ Oxygen Dependent	**OTHER CONCERNS:**	______________________
________________________	☐ Dialysis Dependent	☐ Patient has Pets:	______________________
________________________	☐ Other: _____________	☐ Dog	______________________
________________________	____________________	☐ Cat	______________________
________________________	____________________	☐ Other Pets: ________________	______________________

I, the undersigned, give permission to release the information above to the Emergency Management Office for assistance with evacuation in the event of a Natural Disaster/Emergency. I also give Emergency Service Providers, whether paid or volunteer, permission to enter my home in case of emergency.

Patient Signature: __________________________________ Date: ______________ Witness: ___________________________

Agency Name: ___________________________________Phone: _______________ Person Completing: ______________________

Additional Comments: ____

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FOR USE BY AGENCY SUBMITTING ONLY: DELETION CODES (check one to remove from registration):
☐ MOVED ☐ DISCHARGED ☐ DECEASED ☐ NO LONGER NEEDS ASSISTANCE