NJ Register Ready

(Salem County Special Needs Registry for Disasters)

Please complete & return to:

Salem County Health and Human Services
110 Fifth St.
Salem, NJ 08079
Attn: Jenna Hogate

Are you filing out this form for someone else? ☐ **Yes** ☐ **No**

If yes, what is your relationship to this individual? _____

Your Name: _____ **Your Phone Number**:_____

Your Email:_____

Information about the person requiring assistance:

Is this person already a NJ Register Ready user and want to update your information? ☐ **Yes** ☐ **No** ☐ **Unsure**

Full Name:_____

Date of Birth:_____ **Phone Number**:_____

Physical Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Email:_____ **Height**:_____ **Weight**:_____

Uses TDD/ TTY? ☐ **Yes** ☐ **No** **Eye Color**: _____ **Gender:** ☐ **Male** ☐ **Female**

Information about individual's condition or situation

This is to provide medical or emergency personnel with any information that may be vital to know in case of an urgent situation.

Must choose at least one option:

- ☐ Sight Impaired
- ☐ Hearing Impaired
- ☐ Speech Impaired
- ☐ Physically Impaired
- ☐ Completely Bedridden
- ☐ Requires constant skilled nursing skills
- ☐ Dialysis
- ☐ Dementia/Alzheimer's
- ☐ Mentally/Memory Impaired
- ☐ Diabetes
- ☐ Developmentally Disabled
- ☐ Autism Spectrum Disorder
- ☐ Other Reason Needing Assistance
- ☐ None

If other, please describe:

_____
_____
_____

Does not:

- ☐ Have access to a motor vehicle
- ☐ Have a radio or television
- ☐ Have a telephone
- ☐ Speak English

Primary Language:_____

Has difficulty walking and requires:

- ☐ Manual Wheelchair
- ☐ Motorized Wheelchair
- ☐ Walker/Cane
- ☐ Attendant to assist in ambulating
- ☐ Hoyer lift

Requires medical equipment that is not easily transportable:

- ☐ Oxygen concentrator or cylinder
- ☐ Ventilator
- ☐ Suction Machine
- ☐ CPAP Machine
- ☐ BiPAP Machine
- ☐ Nebulizer
- ☐ Feeding Pump
- ☐ Other (explain below):

_____
_____
_____

Are all conditions resulting in the need for evacuation assistance temporary?

☐ **Yes** ☐ **No**

Do you have medications that must be taken with you if evacuated?

☐ **Yes** ☐ **No**

Do you have a service animal?

☐ **Yes** ☐ **No**

Do you have a 24 hour caretaker?

☐ **Yes** ☐ **No**

If yes, will the caretaker travel/ and/ or stay with you? ☐ **Yes** ☐ **No**

Caretaker's Full Name:_____

Caretaker's Phone Number:_____ **Caretaker's Email**:_____

Do you require evacuation assistance 24/7? ☐ **Yes** ☐ **No**

<u>Emergency Contact Information:</u>

Emergency Contact Full Name:_____

Phone Number:_____ **Address**:_____

City:_____ **State**:_____ **Zip Code**:_____

Emergency Contact's Email:_____

Relationship to Individual:_____