LEXINGTON FAYETTE COUNTY SPECIAL NEEDS REGISTRY FORM

Type information in the fields below. Click the 'Submit by Email' button.
Print and sign the form, then mail (see mailing instructions at end of form).

Submit by Email

Reset Form

Date ☐ New Application ☐ Update of Previous Application

PERSONAL INFORMATION

First Name ☐ Last Name ☐ Mid Initial ☐ Date of Birth ☐ ☐ M ☐ F

Street Address ☐ City ☐ Zip ☐

If temporary address, give dates: From ☐ To ☐ Flood Prone Area ☐ Yes ☐ No

Mailing Address ☐ City ☐ Zip ☐

Home # ☐ Cell # ☐ Work/Alt # ☐ Phone/TTY # ☐

Primary Language ☐ Require a translator ☐ Yes ☐ No If so, what language ☐

Email Address ☐ Alternate Email Address ☐

Residence: ☐ Single Family ☐ Multi-Story ☐ Long Term Care ☐ Mobile Home

Living Situation: ☐ Alone ☐ With Spouse ☐ With Caregiver Caregiver name/relationship: ☐

# of Dependents less than 18 years old: ☐

Pets: # Dog(s): ☐ # Cat(s): ☐ Service Animal (Type) ☐ Other (Type) ☐

MEDICAL INFORMATION

Condition/Disability ☐

If temporary condition, give dates From ☐ To ☐

Medications (list all meds needing refrigeration or are narcotics [click on Narcotics List button]): Narcotics List

	Medication Name	Dosage	How Often	Refrigeration?
1.				☐
2.				☐
3.				☐
4.				☐
5.				☐

Home Health Agency ☐

Medical Equip Supply Co. ☐

Other Agency Affiliations (i.e., Hearing, Visual, Developmental, Mental Health Services, Other Special Services) ☐

Dialysis: ☐ Home ☐ Center Dialysis Center ☐ # Times per Week ☐

OXYGEN REQUIREMENTS:

☐ Concentrator ☐ Respirator (Ventilator) ☐ Portable ☐ Suction Machine ☐ Nebulizer ☐ Other

Oxygen Frequency: ☐ Continuous ☐ Treatments Only ☐ PRN (As Needed)

ADDITIONAL MEDICAL INFORMATION:

Height ☐ **Weight** ☐ **Paralysis:** ☐ Complete ☐ Partial **Diabetes** ☐

CHECK ALL THAT APPLY:

☐ Open wounds that require dressing changes How often ☐

☐ Sight Impaired ☐ Hearing Impaired ☐ Memory Impaired ☐ Speech Impaired ☐ Mobility Impaired

☐ High Blood Pressure ☐ Severe Arthritis ☐ Anxiety/Depression ☐ Heart/Pacemaker/Electronic Device

☐ Life-sustaining Meds ☐ Wheelchair User ☐ Bedridden ☐ Incontinent ☐ Sign Lang/Interpretor Needs

☐ Emergency Alert Equipment ☐ DNR Order (if so, attach copy) ☐ Required or Life-Sustaining Med Equip.

☐ Mental Health Impaired (Explain) ☐

☐ Special Dietary Needs (Explain) ☐

☐ Contagious/Infect Disease (Explain) ☐

☐ Other Issues (Explain) ☐

Allergies (Medical and Non-Medical ☐

EMERGENCY CONTACT INFORMATION

First Name		Last Name		Relationship		Phone:	
First Name		Last Name		Relationship		Phone:	
Primary Care Provider				Provider Phone:			
Pharmacy Name				Pharmacy Phone:			

TRANSPORTATION INFORMATION

Do you need assistance to evacuate your dwelling in an emergency? ☐ Yes ☐ No

If you will need transportation assistance, check the type you will need:

☐ Automobile ☐ Van with wheelchair lift ☐ Stretcher ☐ Ambulance (patient must initial) **

** (Note: if ambulance is requested, patient will be responsible for transportation costs of ambulance.)

APPLICANT REPRESENTATIVE

If the person completing this form is not the applicant, please answer the following:

Name _____ Relationship/Agency _____

Applicant has been notified of this registration? ☐ Yes ☐ No

Sign _____ Date _____

PRIVACY STATEMENT

We respect your right to confidentiality and continuously take every possible measure to ensure that your personal information remains confidential. We do not collect or maintain information about you that is not essential for your safety and well-being.

All employees of the Lexington-Fayette County Health Department and the Lexington Fayette Urban County Government Division of Emergency Management are required to adhere to this privacy statement of confidentiality and nondisclosure.

AUTHORIZATION INFORMATION

I authorize emergency response personnel to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare. I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

I hereby provide my consent for the members of the Lexington-Fayette County Health Department and the Lexington Fayette Urban County Government Division of Emergency Management to have access to the medical information contained in this form. I further understand that only those persons who have a 'need to know this information' will have access to it. This release remains in effect until further notice unless revoked by me in writing.

I agree that my name be added to the Special Needs Emergency Shelter Registry. I understand that this form is not a reservation for the Special Needs Shelter, but that my medical information will be used to determine/assess plans appropriate for my care and treatment during an emergency.

I understand that the Special Needs Shelter may not be air conditioned if emergency power is required. I understand that I need to bring with me all medications, in marked bottles, and all medical supplies I use for my care for up to 7 days (one week).

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Division of Emergency Management may determine which emergency evacuation assistance, if any, this program may be able to provide.

Sign _____ Date _____

☐ Check this box if you want "Check-up" service. This is a monitoring service that will call to check up on your welfare. If you don't answer or need assistance, your emergency contact(s) listed in this form will be notified.

If you don't want to submit by e-mail,
click the Print Form button, sign and mail to:
DEM, 1793 Old Frankfort Pike, Ste 50, Lexington, KY 40504
or fax to 859-252-8689.

Print Form

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