



# TOWN OF EAST HAMPTON

Department of Human Services  
128 Springs Fireplace Road  
East Hampton, NY 11937

Diane Patrizio, Director

Telephone: (631) 329-6939

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## EMERGENCY ASSISTANCE FOR EAST HAMPTON TOWN RESIDENTS WITH **SPECIAL NEEDS**

The Town of East Hampton Department of Human Services has developed a computerized registry of all town residents with **SPECIAL NEEDS** who need to receive evacuation and shelter assistance during natural disasters like hurricanes or severe flooding.

This is a free and voluntary registration. The information you provide will be confidential, in accordance with State law. It will be used by emergency personnel only to assure your safe and timely evacuation. Please fill out the questionnaire and return it to:

Diane Patrizio, Director  
Department of Human Services  
128 Springs Fireplace Road  
East Hampton, N.Y. 11937

**Please note:** For those Senior Citizens **who may not** have special needs but would like to be on our “Reassurance Calling List”, please fill out attached form **up to** “Phone Call Only” section and return to address above.

For more information or additional questionnaires call 329-6939 or the N.Y. State Relay # 1-800-662-1220.

(Note to Agency’s: Please add your agency’s contact person and fax number at the bottom of the registry form.)

TOWN OF EAST HAMPTON  
**EMERGENCY EVACUATION REGISTRY**

**2016**

Name \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M\_\_\_\_ F \_\_\_\_

Street Address \_\_\_\_\_

Nearest Cross St. \_\_\_\_\_

Mailing Address \_\_\_\_\_

Fire District \_\_\_\_\_

House No. \_\_\_\_\_ Apt. No. \_\_\_\_\_

Telephone No. \_\_\_\_\_

Primary Language \_\_\_\_\_

Single Family Home \_\_\_\_\_ Mobile Home \_\_\_\_\_

Apartment/Condo \_\_\_\_\_ Floor \_\_\_\_\_

Seasonal Res? \_\_\_\_\_ When? \_\_\_\_\_

**I need a phone call only:** Yes \_\_\_\_\_

Will you be accompanied to the shelter?

Yes \_\_\_\_ By Whom \_\_\_\_\_ No \_\_\_\_\_

Do you live alone? Yes \_\_\_\_\_ No \_\_\_\_\_

If "No", Family? \_\_\_\_\_ Caretaker? \_\_\_\_\_ Other \_\_\_\_\_

Number of People \_\_\_\_\_

Next of kin or Guardian's Name & Phone #:

\_\_\_\_\_

Are you receiving Home Health care (Y/N) \_\_\_\_\_

Name & Phone Number of Agency:

\_\_\_\_\_

Signature \_\_\_\_\_

Disability/Medical Condition:

Legally Blind \_\_\_\_\_ Deaf \_\_\_\_\_

Hard of Hearing \_\_\_\_\_ Speech Impaired \_\_\_\_\_

Mobility Impaired \_\_\_\_\_ Diabetic \_\_\_\_\_

Hypertension \_\_\_\_\_ Other \_\_\_\_\_

Are you confined to: Bed? \_\_\_\_\_ Crutches \_\_\_\_\_

Wheelchair \_\_\_\_\_ Walker/Cane \_\_\_\_\_

Other \_\_\_\_\_

If you use a life support system, complete:

Instructions/ Portable? Hours/Day \_\_\_\_\_

Oxygen \_\_\_\_\_

Respirator \_\_\_\_\_

Electrical \_\_\_\_\_

Dialysis \_\_\_\_\_

Other \_\_\_\_\_

Special Transportation Needs?

Lift Gate Vehicle \_\_\_\_\_ Ambulance \_\_\_\_\_

Barriers to entering house \_\_\_\_\_ Pets? \_\_\_\_\_

Do you have a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes", what type? \_\_\_\_\_

Are you on medication? \_\_\_\_\_

(If yes, please list on back of form.)

Do your medications need refrigeration? Y / N

**FOR OFFICIAL USE ONLY:**

Filed by: Agency Name: \_\_\_\_\_ Contact: \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_