



The NJ Special Needs Registry is...

- free*
- voluntary*
- strictly confidential*
- protective of your privacy*
- a way to protect you in a major emergency*

This special needs registry is designed to help emergency responders locate and safely evacuate people who could find it difficult to help themselves in the event of a major disaster. Advanced planning and preparedness is important for people with special needs, which includes anyone who may find it difficult to evacuate on their own because of a physical limitation (including using a cane or walker, have difficulty with steps, cannot get out of the house without help), cognitive limitation, language barrier, or lack of transportation – particularly if family, friends or caregivers are likely to be at work or at a distance from your home and not available to help during a crisis.

Emergency responders need to know where you are and what kind of help you might need if there was a need to safely evacuate you quickly. Complete this form for yourself or anyone you know who may need assistance in an evacuation. This information is considered confidential. No information will be intentionally shared with anyone other than the emergency responders and participating agencies.

If you would prefer to mail this form, please send to Christine Florio, Sussex County Division of Community and Youth Services, One Spring Street, Newton, NJ 07860.

SECTION 1A: Your Personal Information					
First Name		M.I.	Last Name		
Address					
City, State, Zip Code		Municipality		County	
Primary Phone <input type="checkbox"/>		Cell Phone		<input type="checkbox"/> I do not have a phone.	
TTY/TTD					
E-mail		Date of Birth	Height	Gender	<input type="checkbox"/> Weight over 300 pounds
SECTION 1B: Emergency Contact Information					
In the event of an emergency, we may need to get in contact with and emergency contact. Please enter the personal information for your emergency contact below.					
<input type="checkbox"/> I choose not to provide emergency contact information.					
First Name		M.I.	Last Name		
Address					
City, State, Zip Code		E-mail			
Primary Phone		Cell Phone			
Emergency Contact's Relationship to You					
<input type="checkbox"/> Friend <input type="checkbox"/> Family Member <input type="checkbox"/> Neighbor <input type="checkbox"/> Caregiver <input type="checkbox"/> Other					



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SECTION 2: Limitations/Conditions/Needs

If there is an emergency requiring evacuation, you may have difficulty evacuating or being notified of the need for evacuation because of the following. Check all that apply:

<input type="checkbox"/> Sight impaired <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Speech impaired <input type="checkbox"/> Physically impaired <input type="checkbox"/> Completely bedridden <input type="checkbox"/> Mentally/memory impaired <input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> Dialysis <input type="checkbox"/> Require constant skilled nursing care <input type="checkbox"/> Other reason for needing assistance	<p>I do not:</p> <input type="checkbox"/> Have access to a motor vehicle <input type="checkbox"/> have a radio <input type="checkbox"/> Have a television <input type="checkbox"/> Speak English My primary language is: _____
<p>I have difficulty walking and require:</p> <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Motorized wheelchair <input type="checkbox"/> Walker/cane <input type="checkbox"/> Attendant to assist in moving	

I require medical equipment that is not easily transportable:
 Oxygen concentrator or cylinder Ventilator Suction machine Other equipment

SECTION 3: Duration of Need

1. Do you have a service animal (e.g., a seeing eye dog)? If yes, describe in Section 5	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have any pets? (If yes, describe what and how many in Section 5)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have medications that must be taken with you if you are evacuated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have a 24-hour caregiver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you require evacuation assistance 24 hours a day, 7 days a week? <input type="checkbox"/> Yes <input type="checkbox"/> No, I need evacuation assistance FROM _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. TO _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
6. Are you a seasonal resident? <input type="checkbox"/> No <input type="checkbox"/> Yes FROM _____ (month) TO _____ (month)	

SECTION 5: Additional Information/Comments

Please enter any additional information that may be useful for our emergency personnel to have in order to evacuate you.