City of St. Louis - Functional Needs Registry

_____
Last First Middle Initial

_____ ☐ Male ☐ Female
Address Apt # Bldg # Zip Code

_____
Home Phone /TTY Cell/Work Phone # Email

Date of Birth:_____/_____/_____ Social Security #:_____

Primary Language: _____ # of individuals living in the household: _____

Primary Physician: _____ Physician Phone #: _____

Pharmacy: _____ Pharmacy Phone #: _____

Emergency
Contact: _____
Last First Home Ph # Cell/Work Ph#

_____
Address Apt.# City State Zip Code

Email: _____ Relationship to Registrant: _____

Are you confined to your home? ☐ Yes ☐ No Do you have? : ☐ Elevator ☐ Stairs How many?____

Do you have an A/C for cooling? ☐ Yes ☐ No If Yes ☐ Central Air ☐ Window #_____
What is the source of your Heat? ☐ Gas ☐ Electric ☐ Other_____

Disability Type: ☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impairment ☐ Hospital Bed
☐ On life support ☐ Feeding tube ☐ Oxygen ☐ Ventilator ☐ Wheelchair ☐ Bedridden
☐ Require IV ☐ Catheter ☐ Asthma ☐ Obese/Frail ☐ Pregnant

Other Medical Conditions: _____

Is Your Disability: ☐ Permanent **or** ☐ Temporary (please give a medical release date: ____/_____/___)

Unless you notify registry personnel, you will be deleted from registry as of the above date.

Have you ever been diagnosed with a mental health problem? ☐ Yes ☐ No
Please explain_____

Do you have pets? ☐ Yes ☐ No Service Animal ☐ Yes ☐ No
Do you have arrangements for them in an emergency? ☐ Yes ☐ No
Please explain_____
Please be advised that pets may NOT accompany you to a shelter unless they are service animals.

Transportation (check all that apply)
☐ I will provide my own transportation ☐ I am ambulatory ☐ I can get to a bus pickup point
☐ I can move with assistance ☐ I need assistance ☐ I need a wheelchair lift equipped vehicle
☐ I can transfer from a wheelchair to a seat ☐ I am bedridden and require stretcher transport

Evacuation Information
I can exit my home on my own ☐ Yes ☐ No Will you require evacuation assistance? ☐ Yes ☐ No
Do you: ☐ Care for yourself **or** ☐ Regularly have assistance from a caregiver

Name of Caregiver: _____ Phone #:_____

Address: _____ City:_____ Zip:_____

Are you able to feed yourself? ☐ Yes ☐ No Do you require assistance transferring? ☐ Yes ☐ No
Do you have any comments/suggestions that may assist us in your care during evacuation? _____
_____

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What illness do you take medication for (check all that apply):
☐ Heart problems☐ Blood pressure ☐ Stroke ☐ Diabetes ☐ Breathing problems
☐ Back problems ☐ Seizures/convulsions ☐ contagious diseases ☐ Dialysis, # weekly_____
☐ Other (describe):_____
Do you require a special diet? ☐ Yes ☐ No If yes, what type?_____
☐ Self administered, shelf kept
☐ Intravenous, self administered, refrigeration required, please list: _____
☐ Non self administered medication required
☐ Medicine Allergy, if so what medicine(s):_____

Medications:

_____

_____

The Functional Needs Registry is being developed under the St. Louis City Health Commissioner's Investigation authority and is not public information. All data obtained and maintained in the Functional Needs Registry may be shared only with other public health authorities and co-investigators while planning for or during a public health emergency, provided they abide by the same confidentiality restrictions required by the St. Louis City Department of Health under sections 192.067, RSMo. and the Federal Health Insurance Portability and Accountability Act (HIPAA).

Authorizations:

I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I herby grant permission for the release of this information to emergency response agencies and preauthorize these agencies to enter my residence for the purpose of emergency search and rescue. I understand my participation in this registry is voluntary and all information maintained will be strictly confidential, used only for emergency purposes and hereby request registration in the City of St. Louis Functional Needs Registry. I understand that being on the registry in no way ensures that I will receive any, immediate, or preferential treatment during an emergency.

I understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. The information contained herein is true and correct to the best of my knowledge. I understand that any assistance that might be provided is only for the duration of emergency, and that alternative arrangements should be made in advance in case I am not able to return to my home.

I understand, based on the information I have provided, that I may or may not be assigned to a functional needs shelter based on the criteria stated in the information I provided. I understand that I am responsible for assisting in the provision of any prescription medications, oxygen supplies, medical equipment, and dietary items I may require during the emergency.

Registrant Signature: _____Date: _____/_____/_____

Caregiver: _____ Date: _____/_____/_____ (*if registrant is unable to sign)*

Relationship to Registrant (if any):_____

Please Mail form to:
The City of St Louis, Department of Human Services Attn: FNR
1520 Market Street, 4th Floor St. Louis, MO 63103
or **Fax to: 314-612-5915**

Please contact (314) 612-5916 in the event any of the above information changes at any time, such as an address change, medical change, etc. You will be contacted by our office if we have any questions regarding your application, and periodically contacted to update our records. Or visit our website at **http://www.stlcityfunctionalneeds.org.**

Agency Use only

Date Registered: _____

Updated: _____