TOWNSHIP OF PISCATAWAY

OFFICE OF EMERGENCY MANAGEMENT

455 Hoes Lane • Piscataway • NJ 08854-2704

SPECIAL NEEDS REGISTRY

FREQUENTLY ASKED QUESTIONS

What is the Special Needs Registry?

It is a list of Piscataway Township residents who may require additional assistance, transportation and/or sheltering in the event of a major emergency or disaster.

Who is eligible for the Special Needs Registry?

Any Piscataway Township resident with physical and/or mental limitations that would have difficulty leaving their home quickly if told to do so. The Registry is only intended for those who live independently and not in a residential special needs facility.

Will my information be kept confidential?

Yes, however the Township will share the information with local, state, and federal agencies for the purpose of emergency planning and response. The information collected will be kept secure and maintained by the Piscataway Township Emergency Management Office and would only be used in the event of a disaster.

Is the "Special Needs Registry" and "911" Telephone Service the same thing?

No. You must still dial 911 on your telephone for assistance in an emergency

Is participation in the Registry voluntary?

Yes. Your submission of an application is your voluntary request to be included. You may request to be removed at any time from the Registry by writing to:

Mildred Hall, Office Manager
Piscataway Senior Center
700 Buena Vista Drive
Piscataway, New Jersey 08854

The submission of an application does not guarantee your inclusion in the Registry. Each application will be screened and evaluated on a case-by-case basis. You will be notified by mail of your acceptance or denial into the Registry.

Applications must be completed in English, signed by applicant and/or caregiver; and returned to Mildred Hall at the address indicated above.

PISCATAWAY TOWNSHIP'S SPECIAL NEEDS REGISTRY
REGISTRATION FORM

1) PERSONAL INFORMATION **(PLEASE PRINT CLEARLY)**

Last Name:	First Name:	MI:
DOB:	Gender: Male ☐	Female ☐
Physical Address:		Apt No._____
Mailing Address:		
Email Address:		Primary Language:
Phone #	Cell #	TTD/TTY: Yes ☐ No ☐

2) EMERGENCY CONTACT (S):

Name: Relationship:	Name: Relationship:
Address: Email:	Address: Email:
Phone #:	Phone #
Cell Phone #	Cell Phone #

3) DWELLING CHARACTERISTICS

What type of dwelling do you live in?

Single Family Home ☐ Multi-Family Apartment ☐ Condominium Complex ☐
Does anyone else live with you? Yes ☐ No ☐
If applicable, how many people live with you? _____

Does anyone living with you have a disability? Yes ☐ No ☐

In case of a disaster, what do you plan to do?
☐ Stay at home (if the situation is safe to do so)
☐ Evacuate to a shelter
Can you get to a shelter on your own? Yes ☐ No ☐
☐Care Giver will accompany you to the evacuation shelter
☐Stay with family or others. If other than Emergency Contact, please give:

Name: **Relationship:**

Address: **Phone #**

4) EMERGENCY PREPARATIONS (PLEASE PRINT CLEARLY)

Do you currently have these items?
A Family/Individual Disaster Plan? Yes ☐ No ☐
An Emergency Supplies Kit ***including your needed medical supplies?*** Yes☐ No ☐

5) TRANSPORTATION NEEDS

Self-Ambulatory ☐ Assistance Required ☐ Independent Transfers ☐

Wheelchair User: Manual ☐ Power ☐ Scooter ☐ Ramp ☐
Prosthetic Devices: Indicate type:

Standard Vehicle (bus/car/van) ☐ Ambulance ☐ Lift Equipped ☐
Able to sit in a regular car/bus/van seat: Yes ☐ No ☐

Subject's Weight (To assess evacuation assistance needs:

6) HEALTH HISTORY

Impairment:
Hearing ☐ Sight ☐ Speech ☐ Bedridden ☐ Mentally Disabled ☐

Developmentally Disabled ☐ Dementia ☐ Alzheimer's ☐

Unstable Condition: Cardiac ☐ Pulmonary ☐ Seizures ☐

Equipment Needs:
Life Support ☐ Suction Unit ☐ CPAP ☐ Oxygen Dependent ☐
Apnea Monitor ☐ Spare Cylinders ☐ Feeding Tube/G-Tube ☐

Dialysis:
At Home ☐ At Medical Facility ☐ Frequency _____
Facility Name:

Medications: I.V. Fluids ☐ Insulin ☐ Nebulizer Treatments ☐
Other (specify):

Power Needs:
Do you rely on electricity? Yes ☐ No ☐
Do you have battery back-up Yes ☐ No ☐
Do you have a home generator Yes ☐ No ☐

Special diet:

Contagious Disease(s):

Wound Dressing Changes:

Allergies:

7) HEALTH CONTACTS (PLEASE PRINT CLEARLY)

If applicable, Oxygen Providers Name: _____	
# Hours O2 needed daily/liter Flow per hour	
Type of Oxygen used:	Portable Compressed Gas Cylinder ☐ Portable Liquid Oxygen (O2) Unit ☐ Concentrator ☐
24-Hour Care Giver:	Phone #
Home Health Care Provider:	Phone #
Primary Care Physician:	Phone #
Pharmacy Name:	Phone #

8) PETS

Do you have a Service Animal? Yes ☐ No ☐
If yes, type of animal:_____

Please note that individuals are responsible for caring for the needs of an assistance animal, including bringing food and other essential needs to a shelter.

Veterinarian's Name: Telephone #

Do you have pet(s)? Yes ☐ No ☐
Do you have a pet disaster plan? Yes ☐ No ☐
Do you have Pet Emergency Supplies Kit? Yes ☐ No ☐

Please note that pets may not be allowed in emergency shelters.

Additional Comments or Concerns:

If at any time your condition changes or for any reason this registrant no longer needs to be listed on the Special Needs Registry, please contact:

Mildred Hall, Office Manager
Piscataway Senior Center
700 Buena Vista Avenue
Piscataway, New Jersey 08854

- I certify that the above information is correct.
- I understand that I may be responsible for expenses associated with medical evacuation and shelter at a hospital, nursing facility or for any specialized equipment needed in a special needs shelter.
- I hereby grant permission to release this information to other emergency response or human services agencies or officials.
- I also give local public safety and/or medical personnel permission to enter my home in case of an emergency.
- I understand the limitation on the services and level of care that may be available during a disaster. By registering in this "Special Needs Registry", I understand that there is no guarantee of additional assistance during an emergency. However, I understand that the Township is aware of my circumstances and it will make an effort if the circumstances permit, to attend to my needs.

Signature of Applicant _____Date_____

Signature of Caregiver _____Date_____

Reminder:
Applications must be completed in **English** and signed by Applicant and/or Care Giver

Return to:

Mildred Hall, Office Manager
Piscataway Senior Center
700 Buena Vista Avenue
Piscataway, New Jersey 08854

With your help our community will be better prepared to respond to an emergency and better serve you.