Cochise County
At-Risk Registration Instructions

Dear Registrant,

Enclosed please find an application for At-Risk / Susceptible Individual Shelter and Evacuation Transportation Assistance.

Please read and follow these instructions carefully to prevent delays of your application. If your application is incomplete, we will return it to you for completion.

1. All questions on the application must be answered. Indicate "N/A" for not applicable where necessary.

2. Please print legibly.

3. We require complete mailing addresses for you and **at least one emergency contact.** If your mailing address is different from your physical address, please indicate this appropriately.

4. When completing the transportation information, be as accurate and thorough as possible. This information ensures that you receive the emergency transportation that meets your needs as they are available.

5. We do require information about your additional health care providers, such as home health care agency, dialysis, oxygen provider and the like.

6. Are You Okay? Is a program from provided by the Cochise County Sheriff's Office. Enrollment in this program is voluntary, so this section only needs to be filled out if you wish to enroll. Medical questions asked in previous sections will be used to populate the Are You Okay? Database as applicable.

7. In order for us to process your application, we must have your signed authorization, or the signature of your personal representative, on the Statement of Understanding and Signature Authorization. **All individuals must print their name legibly and sign with their full legal name.** If a home health aide or social worker signs for you, they must also provide the name of the agency they work for.

Completed applications can be mailed or faxed to:

Cochise Health & Social Services
Attn: At-Risk /Susceptible Individual Registry
1415 Melody Lane Bisbee, AZ 85603
Fax: (520) 432-9479

Once we receive your completed application, Cochise Health and Social Services staff will review the information and determine appropriate sheltering and transportation options based on your specific medical conditions and needs. Cochise Health and Social Services will also provide a mailing packet with important information about shelters, our program, evacuation and emergency preparedness.

NOTE: Only service animals, as defined by Federal Law, are permitted in shelters. Information defining service animals is provided in the information packet.

We realize this is a lengthy application and appreciate your patience. We hope you understand that this information is important to you, our staff and emergency responders who will provide assistance to you in an emergency. If you have any questions about the application or our program, please call (520) 432-9400, Monday through Friday 8:00am to 5:00pm.

Thank you,

Cochise County Health & Social Services
1415 Melody Lane, Bisbee AZ 85603

Cochise County
At-Risk Individual Registration

SECTION I: CLIENT CONTACT INFORMATION

ALL QUESTIONS MUST BE ANSWERED IN ORDER FOR YOUR REQUEST TO BE PROCESSED

LAST NAME:_____ **FIRST NAME:**_____ **M.I.**_____

D.O.B. _____/_____/_____ **AGE:**_____ **GENDER:** ( ) Male ( ) Female ( ) Other ( ) No Response
MM DD YYYY

RACE/ETHNICITY:_____ **PREFER NOT TO ANSWER:** ( )

PHYSICAL ADDRESS:_____ **Bldg.#**_____ **Apt.#**_____

DEVELOPMENT/SUBDIVISION:_____ **CITY:**_____ **ZIP:**_____

RESIDENCE TYPE: ( ) Single Family ( ) Apartment / What Floor?_____ ( ) Condo / What Floor?_____
( ) Mobile/Manufactured Home ( ) Recreational Vehicle ( ) Other_____
Is there elevator access? ( ) Yes ( ) No

ARE YOU A SEASONAL RESIDENT? ( ) Yes ( ) No If yes, what months are you here?_____

MAILING ADDRESS (if different than above): _____

DEVELOPMENT/SUBDIVISION:_____ **Bldg.#**_____ **Apt.#**_____

CITY:_____ **ZIP:**_____

LIVING SITUATION: ( ) Alone ( ) Relative ( ) Other_____

PRIMARY TELEPHONE:_____ **SECONDARY TELEPHONE:**_____

IS YOUR PRIMARY PHONE TTY/TDD (teletype)? ( ) Yes ( ) No

CAN OR WILL YOU ACCEPT TEXT MESSAGES? ( ) Yes ( ) No

WHAT LANGUAGE DO YOU SPEAK? Primary_____ **Secondary**_____

EMAIL:_____

WHAT IS YOUR PREFERRED CONTACT METHOD? ( ) Phone ( ) Text ( ) Email ( ) Mail

CAN YOU CHECK EMAIL ON YOUR PHONE? ( ) Yes ( ) No

SECTION II: EMERGENCY / GUARDIAN CONTACT INFORMATION ( ) I prefer not to provide this information

1. **EMERGENCY CONTACT #1 NAME:**_____

RELATIONSHIP:_____ **EMAIL ADDRESS:**_____

COMPLETE ADDRESS:_____

PRIMARY TELEPHONE:_____ **SECONDARY TELEPHONE:**_____

(_____) INITIALING HERE ALLOWS MEDICAL INFORMATION TO BE SHARED WITH THIS INDIVIDUAL
INITIALS

LAST NAME:_____ **FIRST NAME:**_____ **M.I.**_____

SECTION II: EMERGENCY / GUARDIAN CONTACT INFORMATION ( ) I prefer not to provide this information

2. EMERGENCY CONTACT #2 NAME:_____

RELATIONSHIP:_____ **EMAIL ADDRESS:**_____

COMPLETE ADDRESS:_____

PRIMARY TELEPHONE:_____ **SECONDARY TELEPHONE:**_____

(_____) INITIALING HERE ALLOWS MEDICAL INFORMATION TO BE SHARED WITH THIS INDIVIDUAL
INITIALS

SECTION III: EVACUATION TRANSPORTATION INFORMATION

1. Do you require transportation to a shelter? ( ) Yes ( ) No
If you answered "yes" to question #1, do you have any special requirements? For example, do you require assistance transferring from a bed to a wheelchair?

_____

2. How far can you travel on your own using your mobility aid?

( ) I cannot get outside my residence ( ) I can get to my front door ( ) I cannot climb or descend stairs

( ) I can get to the end of my driveway / to the curb in front of my house.

3. MOBILITY: Please check ALL that apply to you.

( ) Able to walk without aid ( ) Bedbound ( ) Cane ( ) Crutches ( ) Electric Wheelchair

( ) Manual Wheelchair ( ) Power Scooter ( ) Blind / Vision Loss ( ) Walker

( ) Require assistance to walk ( ) Artificial Limb _____

4. Do you have a service animal(s) meeting the ADA requirement? ( ) Yes ( ) No Breed:_____

5. Are you able to sleep on a cot or portable medical cot (see information below)? ( ) Yes ( ) No

Do you weigh over 300 pounds? ( ) Yes ( ) No

18 inches high x 32 inches wide x 80 inches long

18 inches high x 30 inches wide x 84 inches long

6. If you are bedbound, are you able to transfer to a wheelchair using a special lift? ( ) Yes ( ) No

7. Will anyone be accompanying you to the shelter? ( ) Yes ( ) No

If Yes, Name/Relationship:_____

8. Total number of persons to be transported from this address? _____

LAST NAME:_____ **FIRST NAME:**_____ **M.I.**_____

SECTION IV: MEDICAL HISTORY

ELECTRIC DEPENDENT ( ) Yes ( ) No If Yes, check ALL that Apply.

( ) Apnea Monitor ( ) BPAP ( ) CPAP ( ) Respirator ( ) Cardiac Monitor ( ) Feeding Pump / Tube

( ) Nebulizer ( ) Suction Pump ( ) Ventilator ( ) Medication requiring refrigeration ( ) IV Pump

( ) Communication Device _____

OXYGEN DEPENDENT ( ) Yes ( ) No If Yes, check ALL that apply.

( ) 24 Hour Use ( ) Overnight ( ) Intermittent Number of hours per day _____ ( ) Concentrator

( ) Portable Tank Mode of Administration: ( ) Nasal Cannula ( ) Face Mask ( ) Liquid ( ) Cylinder

Liters flow / minute: _____ (max 4L / minute) Oxygen Provider:_____ Telephone:_____

COGNITIVE / DEVELOPMENTAL DISORDER ( ) Yes ( ) No If Yes, check ALL that apply.

( ) Anxiety ( ) Aphasia ( ) Autism ( ) Conduct Disorder ( ) Depression ( ) Obsessive Compulsive

( ) Seizures Controlled ____ Uncontrolled ____ Requires caregiver to accompany to shelter*

( ) Alzheimer's / Dementia (All levels) Requires caregiver to accompany to shelter*

( ) Psychosis Controlled ____ Uncontrolled ____ Requires caregiver to accompany to shelter*

( ) Other psychological / developmental disorder: _____

Needs associated with disorder:_____

Disorder Triggers:_____

SPECIAL CARE ( ) Yes ( ) No If Yes, check all that apply.
*

( ) Assistance with administering medication ( ) Assistance activities (bathing, dressing, feeding, or other)

_____

( ) Requires constant nursing care ( ) Catheter ( ) Contagious Disease ( ) Currently under Hospice Care

( ) Incontinence Bladder ____ Bowel ____ Menses_____

( ) Wound / Rash / Open wound requiring care or dressing changes

( ) Dialysis Number of times per week ____ Home ____ Peritoneal ____ Facility _____

OTHER HEALTH CONCERNS ( ) Yes ( ) No If Yes, check all that apply.

( ) COPD ( ) Cardiac Stable ____ Unstable ____ ( ) Frail / Elderly ( ) ALS ( ) Cancer

( ) Parkinson's ( ) Diabetic Insulin Dependent ____ Non-Insulin ____ ( ) Fluid Restrictions

( ) Deaf/Hearing Loss ( ) Hearing Aids

( ) Other assistive device_____

Other:_____

_____

LAST NAME:_____ **FIRST NAME:**_____ **M.I.**_____

SPECIAL DIET ( ) Yes ( ) No If Yes, please explain.

_____
_____
_____

ALLERGIES ( ) Yes ( ) No If Yes, please explain.

_____
_____
_____

MEDICATIONS Please list. _____
_____
_____
_____
_____

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? ( ) Yes ( ) No

SECTION V: MEDICAL SUPPORT CONTACT INFORMATION

PRIMARY CARE PROVIDER

NAME:_____ **TELEPHONE:**_____

ADDRESS:_____

CITY / STATE / ZIP:_____

HOME HEALTH CARE AGENCY / SUPPORTED OR ASSISTED LIVING / NURSING HOME / OTHER

NAME:_____ **TELEPHONE:**_____

POINT OF CONTACT:_____

ADDRESS:_____

CITY / STATE / ZIP:_____

DIALYSIS CENTER:_____ **TELEPHONE:**_____

ADDRESS:_____

CITY / STATE / ZIP:_____

HOSPICE:_____ **TELEPHONE:**_____

ADDRESS:_____

CITY / STATE / ZIP:_____

LAST NAME:_____ **FIRST NAME:**_____ **M.I.**_____

SECTION VI: Are you ok? (RUOK) Cochise County Sheriff Department Registration

The Are You Okay Program is a way for those who are homebound, physically incapacitated, or otherwise unable to be in regular contact with someone to help in the event of an emergency. The program requires participants to sign up and provide basic personal information and a signed liability waiver to be added to the Sheriff's Office subscriber list. Once a resident is added to the list, a telephone call will be made to them at their requested interval such as once a day, twice a week, etc. If there is no answer after several tries, then a Point of Contact will be requested to check on the subscriber. If there is no Point of Contact available, then a Law Enforcement Officer will be sent to check on the subscriber.

I wish to have the Are You Okay System contact me: ( )

Daily ( ) or pick days

( ) Monday ( ) Tuesday ( ) Wednesday ( ) Thursday ( ) Friday ( ) Saturday ( ) Sunday

And the system should contact me at ____:_____ ( ) am and/or ( ) pm

In the event I do not answer the Are You Okay? Call on the date(s) and the time I indicated above, I authorize the Cochise County Sheriff's Office to send a law enforcement officer to check on my well-being. I further authorize the listed people on pages 1 and 2 to be contact, to check on my welfare or offer further assistance.

Please provide the following additional information for the Are You Okay? System.

Ethnicity:_____ Height:_____ Weight:_____ Complexion:_____

Build:_____ Hand (L / R):_____ Hair Color:_____ Hair Style:_____

Eye Color:_____ Occupation:_____ Employer:_____

Employer Address:_____
Street City State Zip Code

Additional Details:

1. If the registered person has a tendency to wander, please describe places he/she have been found recently or may choose to go:

_____

2. Medical or psychological concerns relevant to sheriff attempting to assist the registered person to remain safe and stay or leave home:

_____

3. Items the registered person wears/possesses on a regular basis (such as medical devices, personal items or objects):

_____

4. Suggestions for ways the sheriffs' deputy can approach and help the registered person:

_____

5. Regular behaviors and/or special interests:

_____

6. Medications the registered person MUST take to avoid a medical emergency:

_____

LAST NAME:_____ **FIRST NAME:**_____ **M.I.**_____

SECTION VII: STATEMENT OF UNDERSTANDING AND SIGNATURE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information contained herein is true and correct to the best of my knowledge. I understand that if accepted, assistance will be provided only for the duration of the emergency, and that alternative arrangements should be made in advance in case I am unable to return to my home.

I understand that based on this application and the data I have provided, Cochise Health and Social Services along with Cochise Office of Emergency Services will determine which sheltering and emergency evacuation assistance, if any, this program may be able to provide.

I hereby voluntarily and knowingly agree to release and hold harmless Cochise County, Cochise Health and Social Services, Cochise County Office of Emergency Services and/or any other Public Safety Organization who responds to assist against any claim in relation to services received through the Are You Okay? Program and At-Risk / Susceptible Population Database.

I understand that this registration is voluntary and hereby request registration in the Cochise County At-Risk / Susceptible Individual Shelter and Evacuation Transportation Assistance Program.

By signing this form I give my authorization for medical information contained herein to be released to the Cochise Health and Social Services, Cochise Office of Emergency Services, Canyon Vista Medical Center, Copper Queen Community Hospital, Benson Hospital, Northern Cochise Community Hospital, Southern Arizona Health Care Coalition and its partners, other medical providers and facilities, fire, emergency medical service and police departments for the purpose of evaluating my needs and providing transportation and sheltering. I understand that this application will expire annually on December 31st and require re-validation prior to March 31st or I will be removed from the program. I further understand that if Cochise County requests updated information or cannot contact me due to changes in my information that may remove me from the registry.

Applicant / Patient Full Legal Name (PRINT):_____

Applicant / Patient Signature:_____ Date:_____

If this authorization is signed by an individual's personal representative, or health care provider, on the behalf of the individual, please complete the following:

Personal Representative's Full Legal Name:_____

Healthcare Agency:_____

Contact Information (Include telephone number):_____

Relationship to Individual:_____

Personal Representative's Signature:_____ Date:_____

Completed applications can be mailed or faxed to:

Cochise Health & Social Services
Attn: At-Risk /Susceptible Individual Registry
1415 Melody Lane Bisbee, AZ 85603
Fax: (520) 432-9479

If you have any questions about this authorization or to revoke this authorization prior to the expiration date or event, you must submit a written request to the address above.