



ALBANY COUNTY SHERIFF'S OFFICE

William C. Cox
Undersheriff

CRAIG D. APPLE, SR.
SHERIFF

Paul M. Courcelle
Chief Deputy



Dear Albany County Resident:

The Albany County Sheriff's Office has created a Countywide Registry for Persons In Need for residents of Albany County. The program is designed to assist the special needs community who are physically unable or require assistance to evacuate their homes during an emergency situation. These emergencies can be acts of nature such as a hurricane, tornado, flood, or manmade emergencies such as a terrorist attack, chemical spill, etc., any emergency situation requiring evacuation that could occur in Albany County. The Registry was created as a result of Section 23-a of the Executive Law of New York State. In addition to evacuation during an emergency situation, the information from the application process will be input into the County E-911 system to be utilized for a routine distress call allowing emergency responders to instantly identify the special needs of callers from their residences. In situations like this, prior knowledge of the needs of the caller and response time could make a difference for the awareness of the responders during this crucial time. This Registry is the most extensive of its kind in the Capital District.

The Registry is voluntary and all information obtained will be utilized for emergency purposes only and will be strictly confidential. The applications should be completed and returned to the Albany County Sheriff's Office, Community and Emergency Services, 58 Verda Avenue, P.O. Box A, Clarksville, NY 12041.

Forms are also available on the Albany County Sheriff's website: www.albanycountysheriff.com. If you require assistance filling out the form, you may contact Linda Nash at 720-8030 or email her at: Lnash@albanycounty.com

Sincerely,
GARRY G. HORNE
Director
Community and Emergency Services

Albany County Sheriff's Office
 Community and Emergency Services
 58 Verda Avenue
 P.O. Box A
 Clarksville, NY 12041
 Phone: (518) 720-8030 * Fax: (518) 720-8031

**Evacuation Registration Request Form for Special Needs
 Registry Program**

Last	First	Middle Initial
Address	Apt.#	City
		State
		Zip Code
Home Phone /TTY	Cell Phone	Email

Sex: Male Female Date of Birth: ____/____/____ Weight: _____ Height: _____

Social Security # (optional): _____

Number of relatives living with you who will accompany you to a shelter if need be: _____

Residence Type: Private Home Apartment/Condo Mobile Home High-rise
 Group Home Retirement Home Duplex Dorm

Name of Complex/Subdivision: _____

Yearly resident? Yes No If no, from _____ to _____

Do you have pets? Yes No

Do you have arrangements for them in an emergency? Yes No

Please be advised that pets may NOT accompany you to a shelter unless they are service animals.

Evacuation Information

Will you require evacuation assistance? Yes No

Do you: Care for yourself **or** Regularly have assistance from a caregiver

Name of Caregiver: _____ Phone #: _____ Cell #: _____

Address: _____ City: _____ Zip: _____

Transportation (check all that apply)

- I will provide my own transportation I can get to a bus pickup point
- I am ambulatory, with assistance I Need a wheelchair lift equipped vehicle
- I can transfer from a wheelchair to a seat I am bedridden and require stretcher transport

Is Your Disability: Temporary **or** Permanent

If temporary, please give a medical release date: _____

Note: unless you notify registry personnel, you will be deleted from registry as of the above date.

Type of Disability (check all that apply)

- None Hearing Impaired require a translator, If so specify: _____
- Blind I have a hearing/seeing service animal which will accompany me
- Mental Disability Bedridden Other: _____

Special Equipment (check all that apply)

- Wheelchair dependent collapsible non collapsible Walker/cane
- Electric Dependent Portable Oxygen – Hours per day: _____ Litre Flow: _____
- Other (please describe): _____

(Over)

Medications:

- Self administered, shelf kept Intravenous, self administered, shelf kept
- Intravenous, self administered, refrigeration required, please list: _____
- Non self administered medication required No medicine
- Medicine Allergy**, if so what
medicine(s): _____

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? _____

Type of shelter requested: Standard Special Need

Name of Physician: _____ Phone: _____

Do you have any other comments or suggestions that may assist us in your care during evacuation?

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 hereby grant permission for the release of this information to emergency response agencies and pre-authorize 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 Albany County Special Needs Registry Program.

I also 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 assistance will be provided 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 special needs unit based on the criteria slated 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 back to: Albany County Sheriff's Office
Community and Emergency Services
58 Verda Ave, P.O. Box A
Clarksville, NY 12041

Please contact Linda Nash (518) 720-8030 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.

Agency Use only:

Date Registered:
Updated: _____