

# FRANKLIN COUNTY DEPARTMENT OF EMERGENCY SERVICES

390 NEW YORK AVENUE  
CHAMBERSBURG, PA 17201-7883



PHONE: (717) 264-2813

FAX: (717) 267-2813

Dear Franklin County Resident:

The Franklin County Department of Emergency Services has created a Functional Needs Registry Program for county residents with functional needs. The program is designed to identify those who are physically unable to evacuate their homes during an emergency without assistance. These emergencies can be acts of nature such as a hurricane, tornado, fire, flood, or manmade emergencies including a terrorist attack, chemical spill, or any emergency situation requiring an evacuation. In addition, the information from the application will be input into the county E-911 system to be utilized for routine distress calls. This information allows emergency responders to instantly identify the functional needs of callers. In emergency situations, prior knowledge of the needs of the caller assists responders to plan their response.

The registry is voluntary. All information obtained will be utilized for emergency purposes only and will be kept strictly confidential. The applications should be completed and returned to the Franklin County Department of Emergency Services, 390 New York Avenue, Chambersburg, PA 17201.

Forms are also available at the Franklin County website [www.franklincountypa.gov](http://www.franklincountypa.gov). Click on the General Government tab then the Emergency Services section, click on the forms tab, scroll to the bottom of the page and you will find the functional needs information form.

You may contact Joanne Sheets at (717) 264-2813 or email her at:  
[jksheets@franklincountypa.gov](mailto:jksheets@franklincountypa.gov)

Sincerely,

A handwritten signature in black ink, appearing to read "J. Thierwechter".

John K. Thierwechter  
Director

1000 North Main Street  
P.O. Box 1000  
Trankle, MO 64688

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# Franklin County Department of Emergency Services Evacuation Registration Request Form for Functional 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: \_\_\_\_\_

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: \_\_\_\_\_ Liter Flow: \_\_\_\_\_

Other (please describe): \_\_\_\_\_

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 functional 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.

**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 applies):**

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?

\_\_\_\_\_  
Registrant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_ (if registrant is unable to sign)  
Relationship to Registrant (if any): \_\_\_\_\_

**Please Mail form back to:**

Franklin County Department of Emergency Services  
390 New York Avenue  
Chambersburg PA 17201  
Joanne Sheets (717) 264-2813

*Please contact Joanne Sheets at (717) 264-2813 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.*

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 Franklin County Functional 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.

**Agency Use only:**

Date Registered:

Updated: \_\_\_\_\_