



CITY OF NEW BEDFORD

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HEALTH DEPARTMENT

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# SPECIAL NEEDS REGISTRY

## Frequently Asked Questions

### 1. What is the Special Needs Registry?

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

### 2. Who is eligible for the Special Needs Registry?

Any City of New Bedford 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.

### 3. Will my information be kept confidential?

Yes. However, the City 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 City of New Bedford Emergency Management Agency and would only be used in the event of a disaster.

### 4. Is the "Special Needs Registry" and "E911 Telephone Service" the same thing?

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

### 5. 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:

Mark Mahoney, Director  
New Bedford Emergency Management Department  
834 Kempton Street  
New Bedford, MA. 02740.

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.

### 6. How may I sign up for the Special Needs Registry?

Applications must be completed in English; signed by applicant and/or caregiver; and returned to:  
**New Bedford Health Department, Nursing Division, 1213 Purchase Street,  
New Bedford, MA. 02740. If you need more information, please call: 508-  
991-6287 and ask to speak with a Public Health Nurse.**

# City of New Bedford's Special Needs Registry REGISTRATION FORM

## 1) Personal Information

**(PLEASE PRINT CLEARLY)**

Last Name:	First Name:	MI:
D.O.B.:	Gender: Male <input type="checkbox"/>	Female <input type="checkbox"/>
Physical Address:		Apt No. _____
Mailing Address:		
Email Address:		Primary Language:
Phone #	Cell #	TTD/TTY: Yes <input type="checkbox"/> No <input type="checkbox"/>

## 2) Emergency Contact(s):

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

## 3) Dwelling Characteristics

What type of dwelling do you live in?

Single Family Home       Multi-Family Apartment Bldg

Condominium Complex       Congregate Living Residence/Group Home

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**

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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 Provider's 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 the New Bedford Emergency Management Department at 508-991-6386.***

- 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 service 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 city 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 Care Giver \_\_\_\_\_ Date \_\_\_\_\_

**Reminder:**

Applications must be completed in English; signed by Applicant and/or Care Giver.

**Return to:**

**New Bedford Health Department, Nursing Division, 1213 Purchase Street, New Bedford, MA 02740. If you need more information, please call: 508-991-6287 and ask to speak with a Public Health Nurse.**

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

Thank you for participating in the City of New Bedford's Special Needs Registry.

New Bedford Health Department / Nursing Division