# Rhode Island Special Needs Emergency Registry

*For Rhode Islanders with disabilities, chronic conditions, and special healthcare needs*

The Rhode Island Department of Health (RIDOH) maintains a registry for Rhode Island residents with disabilities, chronic conditions, and/or special healthcare needs who live at home or in group homes. Residents of assisted living residences and nursing homes already have staff to assist first responders. By participating in the Registry, you permit RIDOH to share your information with local and state emergency responders, such as your town/city police and/or fire department. The information that you provide may help responders meet your needs during an emergency, though assistance cannot be guaranteed.

**Instructions:** To be included in the Registry, please fill out this form, sign it, and send it to:

**RIDOH - RISNER, 3 Capitol Hill, Providence, RI 02908 OR register online at www.health.ri.gov/emregistry**

If you have questions, please call **401-222-5960 or RI Relay 711 (TTY)**. If you cannot fill out this form on your own, please have a family member, caregiver, or other representative complete the form and submit it on your behalf.

## GENERAL INFORMATION Fields marked with an asterisk (*) are mandatory. Please print clearly.

Name*: _____
First Name Middle Name Last Name

Gender*: ☐ M ☐ F

Date of birth*: _____ (MM/DD/YYYY)

### PHYSICAL STREET ADDRESS

Street address*: _____ Apartment unit/floor: _____

City/town*: _____ ZIP code: _____

### MAILING ADDRESS AS RECOGNIZED BY THE US POSTAL SERVICE (if different from physical street address)

Street address: _____ Apartment/unit: _____

City/town: _____ State: _____ ZIP code: _____

### CONTACT INFORMATION (* A phone number is required)

Home phone: ( ) - Text only number: ( ) -

Cell phone: ( ) - Videophone number: ( ) -

Email: _____ TTY: ( ) -

### EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: ( ) - Email: _____

## LIVING SITUATION

**I live in Rhode Island (check all that apply to you):**

☐ Seasonally from: _____ (month) to: _____ (month)
☐ Year-round
☐ Split my time between multiple Rhode Island addresses

**I live in (select one type of housing):**

☐ Single family house
☐ Apartment _____ floor
☐ Condo/duplex/townhouse
☐ Mobile home
☐ Other: _____

**I live (check all that apply to you):**

☐ Alone
☐ With family/friends
☐ With caregiver
☐ In a group home operated by _____
☐ In an independent senior living facility
☐ With other people who are disabled
☐ Other: _____

## LANGUAGE

**I prefer to communicate in (select one):**

☐ English
☐ American Sign Language
☐ Spanish
☐ Portuguese
☐ French
☐ Other: _____

## ETHNICITY

Do you consider yourself Hispanic or Latino? ☐ Yes ☐ No

## RACE Select one:

☐ White
☐ African American/Black
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Other: _____

## LIFE SUPPORT SYSTEMS Check all that apply to you:

- ☐ Oxygen tanks
  - ☐ I have spare tanks
- ☐ Oxygen concentrator
  - ☐ I have battery or generator back up for this
- ☐ Respirator/ventilator
  - ☐ I have battery or generator back up for this
- ☐ Tracheostomy
- ☐ IV line
- ☐ Urinary catheters
- ☐ Colostomy/ileostomy
- ☐ Feeding tube
- ☐ Suction
  - ☐ I have battery or generator back up for this
- ☐ Dialysis at a clinic
- ☐ Dialysis at home
  - ☐ I have battery or generator back up for this
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Other electrical needs: _____
- ☐ None of the above

## SENSORY Check all that apply to you:

- ☐ Hard of hearing
- ☐ Use of hearing aid(s)
- ☐ Deaf
- ☐ Use of cochlear implant(s)
- ☐ Visually impaired
- ☐ Legally blind
- ☐ None of the above

## COGNITIVE/PSYCHIATRIC/ NEUROLOGICAL/ MUSCULAR Check all that apply to you:

- ☐ Seizure disorder
- ☐ Speech impaired
- ☐ Non-verbal
- ☐ Cognitively/ developmentally delayed
- ☐ Autism spectrum disorder
- ☐ Alzheimer's/dementia
- ☐ Parkinson's
- ☐ Cerebral palsy
- ☐ Multiple sclerosis
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Obsessive compulsive disorder (OCD)
- ☐ Other: _____
- ☐ None of the above

## MOBILITY Check all that apply to you:

- ☐ Use a wheelchair/mobility vehicle
  - ☐ Wheelchair/mobility vehicle is power dependent
    - ☐ I have battery or generator back up for this
- ☐ Use a walker/cane
- ☐ Use crutches
- ☐ Use prosthesis (specify prosthesis): _____
- ☐ Confined to a bed
  - ☐ Bed is power dependent
    - ☐ I have battery or generator back up for this
- ☐ Other: _____
- ☐ None of the above

## TRANSPORTATION Check all that apply to you:

**When I leave my home, I most frequently use a(n):**

- ☐ Personal vehicle
- ☐ Taxi/car service
- ☐ Public bus
- ☐ RIDE
- ☐ Wheelchair van/bus
- ☐ Ambulance
- ☐ Bicycle
- ☐ Other: _____

**If I needed to evacuate, I would be accompanied by:**

- ☐ No one
- ☐ Caregiver
- ☐ Family/friend
- ☐ Other: _____

## ASSISTANCE REQUIRED Check all that apply to you:

**On a normal day, I require assistance with:**

- ☐ Feeding myself
- ☐ Taking medication(s)
- ☐ Communicating to others
  - ☐ Assistive technology - I use: _____
- ☐ Transportation
- ☐ Using the toilet
- ☐ Dressing/undressing
- ☐ Bathing/grooming
- ☐ Transferring from/to: ☐ Bed ☐ Wheelchair ☐ Toilet ☐ Shower/tub

**Other assistance:**

- ☐ I use a service animal
- ☐ I require supervision
- ☐ I receive medical treatment(s) from a nurse/doctor at home.
- ☐ I receive medical treatment(s) at a healthcare facility at least once a week.
- ☐ Other: _____
- ☐ None of the above

## OTHER DISABILITIES/CONDITIONS

- ☐ Diabetes
  - ☐ I use insulin
- ☐ I weigh between 300 and 549 lbs
- ☐ I weigh between 550 and 799 lbs
- ☐ I weigh 800 lbs or greater

Please list other disabilities or relevant conditions:

_____

_____

_____

_____

**NOTE:** By signing this form, I agree to permit my information to be shared with local and state emergency responders. I understand that this is a voluntary program and while RIDOH will share this information in order to better assist me during an emergency, they cannot guarantee assistance in all cases.

Signature: _____

Print name: _____

Date: _____

If you are completing this form on someone's behalf, please indicate your name and relationship to that individual:

_____