Three Rivers Health District Vulnerable Population Directory Application

The purpose of the Three Rivers Health District Vulnerable Population Directory is to provide emergency responders with important information from individuals that may require assistance during an emergency, (e.g. disease outbreak, power-outage, hurricane, flood, and blizzard). **This program is voluntary and individuals on the directory may decide whether to accept assistance. Completion of this form in no way ensures that the individual completing this form will receive immediate or preferential treatment in an emergency. Individuals are encouraged to construct a personal emergency list and kit.**

Personal Information **PLEASE PRINT CLEARLY**		
Date of Application: ◻ New Application ◻ Request for Personal Emergency Plan List		
Last Name First Name MI	Date of Birth:	Gender/How, do you prefer to be identified?
Street Address Apt. # City Zip	Primary Phone #: Alternate Phone #: E-mail Address (optional):	
Mailing Address (If different) City Zip		
Name of Subdivision, Mobile Home Park, Apt. Building, etc.:________________		
Living Situation (check one): ◻ Live Alone ◻ With Spouse/Partner ◻ With Children ◻ With Parents ◻ Other		
Primary Language:	Do you need the assistance of a translator for English? ◻ Yes ◻ No	
For: Deaf, Hard of Hearing, Deafblind or Difficulty Speaking: Do you use sign language: ◻ Yes ◻ No TTD/TTY #:		

Medical Information (Check those that apply to your medical condition.)

□ Hearing/Visual/Speech Impaired (circle one)
□ Memory/Mentally Impaired (specify condition)
____
□ Developmentally Disabled
□ Sensory Disorder
□ Medically Fragile
□ Seizures
□ Wheelchair Bound
□ Cane or Walker (circle one)
□ Weight in excess of 450 pounds
□ Bariatric needs
□ Ongoing contagious condition (specify)
□ Allergies (specify)
□ Bedridden
□ DNR/Living Will (circle one)
□ Special Dietary Needs* (specify)
If you require a special diet, be prepared to bring with you the appropriate foods in case of emergency

□ I.V. Medication
□ Injections
□ Refrigeration for Medication
□ Insulin Dependent
□ Dialysis patient
□ Incontinence

Supplies______________________________

□ Suction
□ G-tube or NG-tube Feeders (circle one)
□ Dialysis Center or Home (if Yes, circle day(s)
M T W Thu F Sat Sun
□ Portable Oxygen Tank
□ Oxygen Concentrator/Ventilator (circle one)
□ Continuous □ Intermittent (check one)
□ Sleep Apnea Machine
□ Pace Maker/Defibrillator (circle one)
□ Wound Care
Supplies________________________________

Using your usual (customary) language, do you have difficulty communicating?
____

Do you have difficulty understanding or being understood?
____

Any other required or life-sustaining equipment or medication (Use additional space on page 3 if needed):

Do you or anyone in your household need/and or use any Augmentative and Alternative Communication Devices? (E.g. qualified note taker, real-time captioning, telephone headset amplifier, etc.) If so, please list here
____
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Medication Management: ***You are strongly encouraged to prepare an emergency kit with necessary medical supplies and special dietary needs*. Keep kit and your updated list of necessary medications in an easily accessible location.*** *For information on preparing an emergency kit, please* ***visit www.Ready.gov, www.RedCross.org*** *or call Three Rivers Health District Community Outreach Liaison at (804) 758-2381or (804) 291-8080. Forms will be available upon request*

Emergency Contact Information **PLEASE PRINT CLEARLY**

In-State Emergency Contact

Last Name	First Name	Relationship	Phone

Out-of-State Emergency Contact

Last Name	First Name	Relationship	Phone

Medical Provider Information (Fill in all that apply)

Name	Phone
Physician Name	Phone
Pharmacy Name	Phone
Home Health Care Agency Name (or personal caregiver)	Phone
Respiratory Equipment Provider Name	Phone

Transportation Information □

Geographic Location: □ Flood Plain □ Isolated/Difficult to Reach □ Storm Surge Zone □ Mobile Home □ Camper/RV/Winnebago

Can you, a family member or friend provide you with transportation to a shelter in an emergency? □ Yes □ No

If you need assistance with transportation, check one of the following: □ Able to Ride in Car □ Able to ride in van with wheelchair lift □ Able to ride Bus/Taxi □ Ambulance required

Pet Information: Do you have pets that would require special attention if you were asked to evacuate your home? ___________ If so indicate the number of;
_____Service Animals _____Dogs _____Cats _____Other (Describe other)__________________
Pets may not be able to accompany you to the shelter.
Individuals are responsible for caring for the needs of an assistance animal, including bringing food and other essential needs to the shelter. **Service animals are allowed in shelters but must provide proof of current rabies vaccine**.

Emergency Planning

In case of an emergency, do you plan to: (Place an X beside the one that applies.)

1. _____ Stay at home?
2. _____ Stay with family or others?
3. _____ Evacuate to an appropriate facility, independently?
4. _____ Evacuate to an appropriate facility with caregiver?

Covid-19 Vaccination Information

Have you received a 1st dose vaccination for the Covid-19 virus? Yes__ No__ If Yes, please enter the product name, date administered and healthcare professional or clinic site (i.e., Moderna, February 12, 2021 at Clear Creek Internists in Whitewash, Virginia)

Have you received a 2nd dose vaccination for the Covid-19 virus? Yes__ No__ If Yes, please enter the product name, date administered and healthcare professional or clinic site (i.e., Moderna, March 2, 2021 at CVS in Whitewash, Virginia)

If you have not received a 1st dose vaccination, are you interested in receiving one as soon as possible? Yes_____ No_____

Authorization Information

By signing and submitting this form, I/legal guardian agree that my name be added to the Three Rivers Health District Vulnerable Population Directory. In the event of an emergency, I hereby authorize the exchange of information between Three Rivers Medical Reserve Corp, the Disability Team, and the individuals and agencies listed on this form. I grant emergency responders permission to enter my home following an emergency event or disaster situation, if necessary, to assure my welfare and safety.

Applicant Signature	Date
X______________________________	______________

Authorized Guardian Signature	Date
X______________________________	______________

Return Completed Forms to: Three Rivers Health District
Attn: Vulnerable Population Directory, Post Office Box 415 Saluda, Virginia 23149.
Physical address: 2780 General Puller Highway, Saluda

Additional Information/Notes:

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