



HOPEWELL VALLEY  
OFFICE OF EMERGENCY MANAGEMENT  
MERCER COUNTY

## Special Needs Registry

Fill out the following information and return this form to the Hopewell Valley Office of Emergency Management. If you need assistance in completing the form or you want someone to pick up the form for you, please call 737-3100.

*All information will be kept strictly confidential!*

**PERSONAL INFORMATION:**

Date Prepared: \_\_\_\_\_

Name: \_\_\_\_\_  
Last

Spouse: \_\_\_\_\_  
First MI Last First  
MI

Home Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Email: \_\_\_\_\_ Age : \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Male Female

Do you live alone: Yes No Do you have pets: Yes No Do you care for yourself: Yes No

If you have a caretaker please provide the name: \_\_\_\_\_

Caretaker phone #: \_\_\_\_\_

On what floor do you normally sleep? \_\_\_\_\_ Do you normally have access to transportation: Yes No

If transportation is required what type: Accessible Van Accessible Bus Ambulance

Do you receive care in home through a private agency? Community Assistance Home Health Hospice

Agency Name: \_\_\_\_\_ Do you have a service animal: Yes No

Phone number for agency: \_\_\_\_\_

201 WASHINGTON CROSSING PENNINGTON ROAD  
TITUSVILLE, NEW JERSEY 08560  
609-737-3100, FAX 609-737-1775

Are you on oxygen: Yes No If yes, how many hours do you use per day? \_\_\_\_\_

Name of Medical Supplier: \_\_\_\_\_ Supplier Phone: \_\_\_\_\_

Allergic to any medication(s): Yes No Type: \_\_\_\_\_

Please list prescriptions that you are required to take daily: \_\_\_\_\_  
\_\_\_\_\_

Do you require dialysis: Yes No If yes, how frequently? \_\_\_\_\_

Do you have any memory, cognitive, or language impairments? If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

In your home are you dependent on electricity for health or medical equipment: Yes No

What is the name of your electric company: \_\_\_\_\_

Is your memory impaired? Yes No \_\_\_\_\_

Do you have working smoke and/or carbon monoxide detectors? Yes No (note: smoke detectors are available, at no cost, to qualifying residents from the Hopewell Township Fire District)

Would you like a representative from the fire district to assist you in testing your smoke and/or carbon monoxide detector? Yes No

Please include any other information that you feel would be helpful: \_\_\_\_\_  
\_\_\_\_\_

Primary Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

EMERGENCY CONTACT INFORMATION:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone/Cell: \_\_\_\_\_

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