

SNAP



Enrollment Form

Identifying Information

Last Name: _____ First Name: _____ Middle Initial: _____

- Male
 Female

Date of Birth: _____

Address

Number _____ Pre _____ Name _____

Type _____ Suf _____ Unit _____ Number _____

City _____ State _____ Zip _____

Phone : _____ Phone: _____

Email Address: _____

Evacuation

If a local emergency requires you to leave your home, will you go to a:

- Friend or family member's home
 Community shelter
 Hospital or care facility

Will you need transportation?

- Yes
 No
 Automobile
 Lift van
 Ambulance

Emergency Contacts

Primary Contact

Last Name: _____ First Name: _____ Middle Initial: _____

- Family
 Friend
 Caregiver
 Organization, specify: _____
 Neighbor
 Legal Guardian
 Other

Phone: _____ Phone: _____

E-mail Address: _____

Secondary Contact

Last Name: _____ First Name: _____ Middle Initial: _____

- Family
- Friend
- Caregiver
- Organization, specify: _____
- Neighbor
- Legal Guardian
- Other

Phone: _____ Phone: _____

E-mail Address: _____

Submitted By

Last Name: _____ First Name: _____ Middle Initial: _____

- Family
- Friend
- Caregiver
- Organization, specify: _____
- Neighbor
- Legal Guardian
- Other

Phone: _____ Phone: _____

E-mail Address: _____

Primary Physician

Physician Name: Dr. _____ Phone: _____

Please check all that apply

- Life-Sustaining Equipment Required
- Uninterrupted Electrical Service is Essential

Please list below all the equipment that you use:

- Ventilator
- Life Sustaining Medication
 - Cardiac
 - Blood pressure
 - Respiratory
 - Diabetes
 - Other: _____
- Vision Impairment
 - Low vision
 - Legally blind
- Mobility Impairment
 - Walker
 - Wheelchair
 - Scooter
 - Immobile
- Hearing Impairment
 - Hard of Hearing
 - Deaf
- Supplemental Oxygen
- Home Care Assistance
 - Full time
 - Daily
 - Several days/week
 - Monthly
- Service animal
 - Sight
 - Hearing
 - Service
 - Other: _____
- Speech Impairment
- Interpreter Required
 - Language: _____
- Mental or Behavioral Condition

V. Described diagnosed medical conditions, health needs, or needed accommodations:

- Rating: 1 – complex, extremely fragile
 2 – health and/or functional impaired
 3 – General priority
 9 – none

I understand and agree that participation cannot and does not guarantee that I will receive assistance in a local emergency. Disaster conditions are highly unpredictable. Always call 911 in an emergency. Everyone should plan and prepare to be self-sufficient for three to five days. Please carefully review and use the preparedness planning information provided.

Submitted by (Name): _____

- | | |
|---|---|
| <input type="checkbox"/> Family | <input type="checkbox"/> Neighbor |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Legal Guardian |
| <input type="checkbox"/> Caregiver | <input type="checkbox"/> Other |
| <input type="checkbox"/> Organization, specify: _____ | |

Phone: _____ Phone: _____

E-mail Address: _____

We're on the web at www.phsneb.org

