South Central Regional Functional Needs Registry
Enrollment Agreement

Accurate Information and Expiration: The information submitted on my Enrollment Form is true and correct. I agree to keep my enrollment information up-to-date as changes occur. I understand that my enrollment in the Functional Needs Registry will expire annually. I will receive an annual reminder to update my enrollment information and renew my enrollment.

Privacy of Information: The enrollment information submitted to the Registry is protected and used in strict compliance with the Registry's Privacy of Information Policy. The attached policy describes how information is used, security measures, and your rights. Please carefully read the copy provided.

Authorization to Release Information: I have read, understand, and agree to the terms of the Privacy of Information Policy. I authorize administrators of the South Central Regional Functional Needs Registry to use and release my enrollment information within the limitations and for the purposes described in the policy.

Personal Preparedness: I understand and agree that participation can not 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.

Release of Liability: I hereby agree to the fullest extent permitted by law, to indemnify, defend, and Hold Harmless the South Central Regional Functional Needs Registry Coalition, its officers, agents, and employees from and against claims, damages, losses and expenses, including but not limited to attorney's fees, arising out of or resulting from performance of this Agreement, that results in any Claim for damage whatsoever, including without limitation, any bodily injury, sickness, disease, death, or any injury to or destruction of tangible or intangible property, including any loss of use resulting there from, and that are caused in whole or in part by the intentional or negligent act or omission related to the South Central Regional Functional Needs Registry.

Term: The term of this agreement shall be perpetual. I understand I may withdraw from the Disaster Registry at any time and revoke all permissions granted by notifying my local emergency manager or Two Rivers Public Health Department.

Voluntary Agreement: I hereby voluntarily agree to the terms herein and request to be enrolled in the South Central Regional Functional Needs Registry:

Registrant's Signature: _____ Date: _____

Other signature, if the registrant is unable to sign: _____

___I obtained verbal permission. ___I have legal authority, specify: _____ Initial: _____

Printed Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Phone: ( ) _____-_____ Email Address: _____

Mail to: Two Rivers Public Health Department; 701 4th Avenue, Suite 1; Holdrege, NE 68949
Questions or Assistance: 308-995-4778

South Central Regional Functional Needs Registry
Privacy of Information Policy

The South Central Regional Functional Needs Registry takes every precaution to protect the privacy of personal enrollment information in both written and electronic forms.

Use of Information: Enrollment information will only be used for the purposes of:

- Advanced planning and preparedness for a local emergency.
- Guiding search and rescue personnel to those who will urgently need care.
- Providing appropriate medical treatment, care and shelter.
- Reuniting loved ones and care providers after the emergency.

Your name and the precise location of your residence will be shared in advance with law enforcement, fire, and search and rescue personnel to ready them to respond to an emergency.

When South Central Regional Functional Needs Registry activates emergency operations, some or all of the enrollment information collected may be shared on a need to know basis with the organizations that will be actively responding to the emergency.

Those organizations include law enforcement, fire, search and rescue, emergency medical transportation, hospitals, health and human services agencies, and public utilities.

Security of Personal Information: The South Central Regional Functional Needs Registry does not sell, rent, or publish enrollment information. Enrollment information will not be revealed to any unaffiliated third parties for their independent use, except if required by law.

Personnel who are authorized to access enrollment information are specially trained and required to strictly adhere to procedures that protect the privacy of information.

Computer information is managed by data processing professionals and protected by all appropriate safeguards to secure the information system from any foreseeable threat to its security.

Your Rights: As an individual enrolled in the Disaster Registry, you have the right to:

- Examine your enrollment information to ensure it is accurate and up-to-date.
- Be informed of any unauthorized violation of privacy.
- Know of any changes in policy related to the privacy of your information.
- Withdraw from the Disaster Registry at any time and have all your enrollment information completely removed.

If you have any questions regarding your privacy or the Disaster Registry, please contact:

Two Rivers Public Health Department
701 4th Avenue, Suite 1
Holdrege, NE 68949
308-995-4778

Buffalo County Emergency Management: 308-233-3225
Dawson County Emergency Management: 308-324-2070
Franklin County Emergency Management: 308-425-6231
Harlan County Emergency Management: 308-928-2147
Kearney County Emergency Management: 308-743-2442
Region 15 Emergency Management: 308-995-2250

South Central Regional Functional Needs Registry
Enrollment Form

Register online at: http://lancaster.ne.gov/emergency/needs/index.htm

or mail to

Two Rivers Public Health Department; 701 4th Avenue, Suite 1; Holdrege, NE 68949

I. Identifying Information

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

Gender: ❑ Male ❑ Female Date of Birth (m\d\yr) : ____________ Age: _____

Address: _____ Unit # _____ Apt # _____

City: _____ County: _____ Zip: _____

Phone: Work: _____ Home: _____ Cell: _____

E-mail: _____ Email: _____

II. Emergency Contacts

Primary Contact Name: _____

Relationship: ❑ Family ❑ Friend ❑ Caregiver ❑ Neighbor ❑ Legal Guardian
❑ Other or ❑ Organization, specify: _____

Phone: Work _____ Home: _____Cell: _____

E-mail: _____

Secondary Contact Name: _____

Relationship: ❑ Family ❑ Friend ❑ Caregiver ❑ Neighbor ❑ Legal Guardian
❑ Other or ❑ Organization, specify: _____

Phone: Work: _____Home: _____ Cell: _____

E-mail: _____

III. Evacuation: If a local emergency requires you to leave your home, will you:

❑ go to friend or family member's home ❑ go to a community shelter
❑ need to go to a hospital or care facility

Will you need transportation? ❑ Yes ❑ No
If yes, what type of transportation: ❑ automobile ❑ lift van ❑ ambulance

(Over) ➡

IV. Your Health and Circumstances:

Physician Name: _____ Phone: _____

Please Check All that Apply, Check Marks mean Yes:

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

Please list below the equipment that you use:

_____

_____

❑ Ventilator

❑ Supplemental oxygen

❑ Life Sustaining Medication
- ❑ Cardiac ❑ Blood Pressure
- ❑ Respiratory ❑ Diabetes
- ❑ Other: _____

❑ Home Care Assistance
- ❑ Full time ❑ Daily
- ❑ Several days/week ❑ Monthly

❑ Vision Impairment
- ❑ Low Vision
- ❑ Legally Blind

❑ Service Animal
- Type: ❑ Sight ❑ Hearing ❑ Service
- ❑ Other: _____

❑ Mobility Impairment
- ❑ Walker ❑ Wheelchair
- ❑ Scooter ❑ Immobile

❑ Speech Impairment

❑ Interpreter Required
- Language: _____

❑ Hearing Impairment
- ❑ Hard of Hearing
- ❑ Deaf

❑ Mental or Behavioral Condition

IV. Describe Diagnosed Medical Conditions, Health Needs, or Needed Accommodations:

_____

_____

_____

Submitted by (Name): _____

Relationship: ❑ Family ❑ Friend ❑ Caregiver ❑ Neighbor ❑ Legal Guardian
❑ Other or ❑ Organization, specify: _____

Phone: Work: _____ Home: _____ Cell: _____

E-mail: _____