



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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