



**Functionally and Medically
Fragile Populations (FMFP)
Voluntary Registration**

Pitt County Emergency Management has developed a computerized registry of Functionally and Medically Fragile Populations with special care factors who may require assistance in the event of a disaster, such as a hurricane, tornado, severe storm, or chemical spill.

FMFP Needs Include the Following:

1. Individuals with severe respiratory problems (Oxygen or ventilator dependent) who require a power source and/or ambu bag.
2. Individuals dependent on airway suctioning (tracheotomy).
3. Individuals on IV (intravenous) therapy.
4. Individuals requiring tube feeding.
5. Diabetic patients requiring assistance with insulin.
6. Individuals requiring wound care or help with injections on a daily basis.
7. Individuals with physical or mental conditions, including traumatic brain injury, who require daily medical supervision.

Assistance dogs are allowed in Functional and Medical Support Shelters (FMSS); however, individuals are responsible for care of the dog, including bringing food and other essentials. Pets are not allowed in shelters.

Individuals who come to a Functional and Medical Support Shelter are responsible for bringing a five (5) day supply or medications, medical supplies, and any other items needed to meet their needs.

This is a voluntary registration. The information you provide will be confidential in accordance with state and federal privacy laws. It will be used by emergency personnel only to assure your safety in the event of a disaster. You may need to be evacuated to safety, or you may need to stay within your home with special assistance. Should you wish to be included in the registry, **please complete the tear-off questionnaire and return it to REAL CRISIS Center.** If you have questions, call **REAL CRISIS CENTER.**

If you know of someone else who might need disaster assistance, please share this information with them.

Sponsored by

Pitt County Emergency Management
1717 W. 5th Street
Greenville NC 27834
(252) 902-3950

Pitt Aging Coalition
Pitt County Council on Aging
P O Box 7272
(252) 752-1717

REAL Crisis Center
600 E. 11th Street
Greenville NC 27858
(252) 758-HELP(4357)

**DIRECT ALL
INQUIRES TO
REAL CRISIS.**

After completing this form detach and return to: REAL CRISIS (see address at bottom of the left side).

Name: _____ Date of Birth _____
 Your Physical Street Address: _____
 City: _____ Zip: _____ Phone: _____
 Your Mailing Address: _____
 Caregiver: _____ Phone: (h) _____ (w) _____
 Emergency Contact Person: _____ Phone: (h) _____ (w) _____
 Primary Language: _____ **TDD/TTY (for hearing impaired)** _____ Yes _____ No
 Primary Physician: _____ Physician's Phone: _____
 Home Health/Personal Care Provider: _____ Phone: _____
 Pharmacist: _____ Pharmacist Phone: _____

FMFP NEEDS: Circle all medical needs that apply to you as defined by the categories listed in the information on the left.

	1	2	3	4	5	6	7
• What is your primary disaster plan?							
____ 1. Stay with family or others: If so, name, address, phone #: _____							
____ 2. Stay at home _____ Do you have a generator? _____							
____ 3. Evacuate to a shelter (A caregiver must accompany you to the shelter and stay with you)							
____ 4. No sheltering plan							
• Do you have transportation to a shelter? _____ YES _____ NO							
If No, what are your transportation needs? _____ Car _____ Van with lift _____ Ambulance							
• Do you need assistance with walking? _____ Walks Unassisted _____ Walks with Assistance							
_____ Wheelchair _____ Bed Bound							
• Do you presently live in: _____ Apartment _____ House _____ Mobile Home							
• Do you have medical equipment that requires power? _____ Yes _____ No							
• Do you have a living will? _____ Yes _____ No							
• Additional Care Factors							
____ Life Support (emergency power) _____ IV Fluids _____ (frequency)							
____ Insulin (self) _____ Suction Unit _____ (frequency)							
____ Insulin (with assistance) _____ Special Diet (describe) _____							
____ Ventilator _____ Oxygen _____ Hours per day							
____ Wound Care _____ (frequency) _____ Portable Oxygen Tank							
____ 24 hour caregiver _____ Concentrator (for oxygen)							
____ Colostomy (self) _____ Oxygen Provider: _____							
____ Colostomy (with assistance) _____ Traumatic Brain Injury (TBI)							
____ Ileostomy (self) _____ Methadone Treatment							
____ Ileostomy (with assistance) _____ Post Traumatic Stress Disorder							
____ Heart Problems _____ Homebound							
____ Dialysis _____ (frequency) _____ Homeless							
____ Feeding Tube _____ Flood Prone/Hazardous Living Situation							
____ Hearing Impaired _____ Contagious Disease							
____ Sight Impaired _____ Assistance Animal (such as guide dog)							
____ Speech Impaired _____ Other In-home Services _____							

• **Do you have equipment or supplies that you cannot transport?** _____ If yes, please list: _____

I certify that the above information is correct. I understand that I am responsible for all expenses associated with medical evacuation and shelter at a hospital. In the event of an emergency, I hereby authorize Pitt County Emergency Management to release, use or disclose this information to other emergency response or human services agencies or officials. I also give law enforcement permission to enter my home in case of an emergency. I understand I have the right to revoke this authorization as outlined by the Pitt County Notice of Private Practices.

_____ Signature _____ Date _____
 rev.5/09