BOROUGH OF OAKLAND SPECIAL NEEDS SURVEY

PLEASE PRINT CLEARLY and KEEP YOUR INFORMATION UP TO DATE!

NEW SURVEY_____ or UPDATE____ (Fill in ONLY the areas that have changed.)

DATE COMPLETED/UPDATED: _____

PERSONAL INFORMATION:

NAME: First_____ M.I.___ Last_____

STREET ADDRESS:_____

PHONE: Primary (_____)_____- _____ Is Primary Phone TTY/TTD? _____
Secondary Phone (_____) _____-_____ Is this a cell phone?_____

E-MAIL ADDRESS: _____

YEAR BORN: _____ **GENDER**: Male____ Female____ **WEIGHT IS OVER 300 LBS**. _____

EMERGENCY CONTACT INFORMATION:

In the event of an emergency, we may need to get in contact with an emergency contact. Please enter the personal information for your emergency contact below:

NAME: First:_____ M.I. ____ Last:_____

PHONE: Primary: (_____) _____-_____ Secondary Phone: (_____) _____-_____

Emergency Contact's relationship to you: _____

EVACUATION INFORMATION:

If there were an emergency requiring evacuation, you may have difficulty evacuating or being notified of the need for evacuation because of the following condition(s): (Check all that apply.)

1. _____Sight impaired
2. _____Hearing impaired
3. _____Physically impaired
4. _____Completely bedridden
5. _____ Dialysis

I also do not:

6 _____ have access to a motor vehicle
7 _____have a radio or a television
8 _____have a telephone
9. _____speak English
Primary language spoken:_____

I have difficulty walking and require:

10. _____Manual wheelchair
11. _____Motorized wheelchair
12. _____Walker

I require medical equipment that is not easily transportable:

13. _____Oxygen concentrator or cylinder
14. _____Ventilator
15. _____Suction machine
16. _____Other equipment (Please specify)
_____

(OVER)

DURATION OF NEED:

Are **ALL** of the conditions resulting in the need for evacuation assistance temporary? (Example: You are bedridden due to pregnancy difficulties, but are expected to be fully recovered after the baby is delivered.)

_____ **Yes -** Please provide estimated date when condition will be resolved. **Month:**_____**Year**_____
_____ **No,** the condition(s) is expected to be permanent.

OTHER:

1. Do you have a service animal (i.e., seeing-eye dog)? Yes_____ No_____

2. Do you have medications that must be taken with you if evacuated? Yes_____ No_____

3. Does the person in need have a 24-hour caregiver? Yes_____ No_____

4. Does the person in need require evacuation assistance 24 hours/day? Yes_____ No_____

   The person in need requires evacuation assistance: From: _____ AM or PM
   To: _____ AM or PM

5. Is the person in need a seasonal resident? Yes_____ No_____

   The person in need is a seasonal resident: From:_____ To:_____
   (month) (month)

ADDITIONAL COMMENTS / INFORMATION:

Please provide any additional information that may be useful for our emergency personnel to evacuate you.

Please mail or drop off your completed survey to: Oakland Board of Health
One Municipal Plaza
Oakland, NJ 07436