

## Southwest Nebraska 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 Southwest Nebraska 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 Southwest Nebraska 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 Southwest Nebraska 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 Aging Partners.

**Voluntary Agreement:** I hereby voluntarily agree to the terms herein and request to be enrolled in the Southwest Nebraska Functional Needs Registry:

Registrant's Signature: _____ Date: _____
Other signature, if the registrant is unable to sign: _____ Date: _____
<input type="checkbox"/> I obtained verbal permission. <input type="checkbox"/> I have the legal authority, specify: _____ Initial: _____
Print Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: (    ) _____ - _____ Email Address: _____

**Mail to:** Southwest Nebraska Public Health Department, PO Box 1235, McCook, NE 69001  
**Questions and Assistance:** 308-345-4223

## Southwest Nebraska Functional Needs Registry Privacy of Information Policy

The Southwest Nebraska 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 Southwest Nebraska 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 service agencies, and public utilities.

**Security of Personal Information:** The Southwest Nebraska 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 Disaster Registry at any time and have all your enrollment information completely removed.

**If you have any questions regarding your privacy, please contact:**

Southwest Nebraska Public Health Dept.  
404 W 10<sup>th</sup> ST / PO Box 1235  
McCook, NE 69001  
Phone: 308-345-4223  
[www.swhealth.ne.gov](http://www.swhealth.ne.gov)

Chase County Emergency Mgmt  
Dundy County Emergency Mgmt  
Frontier County Emergency Mgmt  
Furnas County Emergency Mgmt  
Hayes County Emergency Mgmt  
Hitchcock County Emergency Mgmt  
Perkins County Emergency Mgmt  
Red Willow Emergency Mgmt

## Southwest Nebraska Functional Needs Registry

Register online at: <http://lancaster.ne.gov/emergency/needs/index.htm>  
or Mail in Enrollment Form

### I. Identifying Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Gender:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Unit # \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_ Email: \_\_\_\_\_

### II. Emergency Contacts

Primary Contact Name: \_\_\_\_\_  
Relationship:  Family  Friend  Caregiver  Neighbor  Legal Guardian  
 Other or  Organization, specify: \_\_\_\_\_  
Phone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Contact Name: \_\_\_\_\_  
Relationship:  Family  Friend  Caregiver  Neighbor  Legal Guardian  
 Other or  Organization, specify: \_\_\_\_\_  
Phone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_ Email: \_\_\_\_\_

### III. Evacuation

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

- Go to a 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

**IV. Your Health and Circumstances:**

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please check all that apply:

- Live-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

**V. 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: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_