



# EDISON

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## Edison's Medical Special Needs Registry Allows Seniors to Prepare for Emergencies

Senior citizens and other Edison residents who rely on mechanical devices such as wheelchairs, dialysis machines, oxygen tanks, those who are bed-bound, do not drive, have trouble with mobility or need additional help due to medical, physical or neurological illnesses are being asked to sign up for a new "special needs registry" designed by Edison's Office of Emergency Management (OEM) to identify individuals who are at risk in our community.

The registry will allow police, fire and other emergency personnel to reach and assist our most vulnerable residents in the event of a natural disaster, fire, electrical blackout or situation which would affect their safety and well being. The list will allow OEM personnel to identify those who may not be able to help themselves before, during or after an emergency situation, alert them to individuals with special needs and assist them in rescue efforts.

The special needs registry has been expanded to include those residents needing medical assistance as well as other vulnerable populations, such as those with speech, hearing and language barriers. Registration is easy and can be done by mail through the Edison Township Division of Senior Citizen Services or on line at [www.registerready.nj.gov](http://www.registerready.nj.gov). Or you may choose to complete the enclosed Special Needs Registry form and mail it to:

Judi Gillingham, Assistant Director for Aging  
Department of Health and Human Services  
Division of Senior Citizen Services  
100 Municipal Blvd.  
Edison, NJ 08817

All information is considered confidential. For additional information regarding the Edison Township Special Needs Registry please call Judi Gillingham, Assistant Director for Aging at 732-248-7345 or you may e-mail her at [jgillingham@edisonnj.org](mailto:jgillingham@edisonnj.org).

# Edison Township - Special Needs Registry

## Edison Senior Citizen Center

The following is strictly for identification with the minimum data requested from individuals with disabilities and frail elderly for senior center staff and township emergency personnel.

### Personal/Residency Information

- First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Last Name: \_\_\_\_\_
- Sex  Male  Female
- DOB \_\_\_\_\_ Date Form Completed: \_\_\_\_\_
- Type of Residence:  Private  Apartment  
Name: \_\_\_\_\_
- Street Address: \_\_\_\_\_ **\*Not a PO Box**  
Address Line 2: \_\_\_\_\_  
Apartment Building Name and Number: \_\_\_\_\_  
Floor Level: \_\_\_\_\_
- Municipality/City: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Cell Phone: \_\_\_\_\_
- Can client read or write English?  
 Well  Not well  Not well at all
- Primary language spoken: \_\_\_\_\_
- Any speech deficits? \_\_\_\_\_
- If Special Needs, Special Needs Residence Type:  
 Assisted Living  Senior Housing  Other
- How many people including yourself are in your household?  
 Live alone  1 other person  2 other persons  3 other persons  
 more than 3 people
- Are you responsible for minor children living with you?  Yes  No  
If yes, how many? \_\_\_\_\_

### Emergency Contact Information

- First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Last Name: \_\_\_\_\_
- Street Address: \_\_\_\_\_ **\*Not a PO Box**  
Address Line 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
- Phone Number: \_\_\_\_\_ Cell Phone : \_\_\_\_\_
- Fax Number: \_\_\_\_\_
- E-mail Address : \_\_\_\_\_

### The following information will further help us prepare for your evacuation

- Do you have pets living with you?  Yes  No
- Do you have a service animal?  Yes  No

- Are you bed bound?  Yes  No
- You walk with the assistance of :
  - No assistance  Another person  Cane  Crutches  Walker
- Do you use a Wheelchair or scooter?  Yes  No  
 Type:  Manual wheelchair  Motorized wheelchair  Scooter
- Sight Impaired?  No impairment  Need glasses  Blind
- Hearing Impaired?  No impairment  Hearing aid  Deaf
- Check all items that apply :
  - Use Oxygen
  - Use respirator
  - Cognitive Impairment
  - Alzheimer/Dementia
  - Developmental disability
  - Mental Health condition

**Evacuation Transportation Requirement**

- Do you require transportation?  Yes  No
- If yes:
  - Standard transportation  Yes  No
  - Can you slide transfer?  Yes  No
  - Do you need vehicle with a lift?  Yes  No
  - Must be transported by Ambulance?  Yes  No

**The following information will be helpful for your possible stay at an Emergency Shelter**

- Do you have :
  - Personal Emergency Kit?  Yes  No
  - Medication list?  Yes  No
  - File/Vial of Life?  Yes  No
  - Food Allergies?  Yes  No
  - If yes, specify \_\_\_\_\_
  - Other Allergies?  Yes  No
  - If yes, specify \_\_\_\_\_
  - Dialysis required?  Yes  No
  - If yes, specify how often \_\_\_\_\_

This form was filled out by  Self  Family Member  Other(name) \_\_\_\_\_