

Please check all that apply.

Maintenance of Health and Medical Needs

- ☐ I use oxygen (tanks/cylinders)
- ☐ I use an oxygen concentrator
- ☐ I use a ventilator
- ☐ I use a CPAP or BiPAP
- ☐ I need assistance with medical treatments (such as wound care, medication management, breathing treatments...)

Transportation

- ☐ I am unable to drive
- ☐ I would need help with transportation in an evacuation
- ☐ I do not have access to private transportation in an Emergency

Independence Needs

- ☐ I use a (circle all that apply):
wheelchair scooter walker cane
- ☐ I am primarily bed-bound
- ☐ I need a power source for my battery operated assistive devices
- ☐ I need bariatric accommodations
- ☐ I need caregiver assistance with non-medical activities such as grooming, bathing, dressing, toileting, and feeding

Animals

- ☐ I have a certified service animal:
Dog Mini Horse
- ☐ I have an emotional support animal: breed:
- ☐ I have pets: breed(s):
- ☐ I have farm animals: breed(s):



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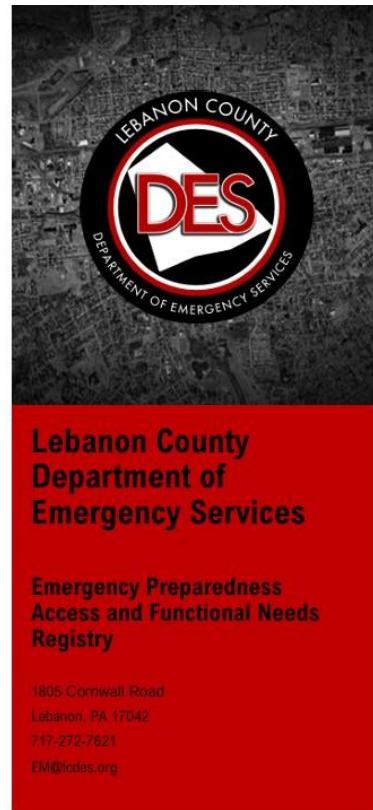
@LebanonDES



Lebanon County Department
of Emergency Services



Lebanon County Special
Operations 50



- Do you have limited mobility?
- Do you require power for your medical devices?
- Do you have a visual or hearing impairment that would impair your ability to know that a disaster is imminent or that an evacuation is needed?
- Do you have a child with special needs?
- Do you have special medical needs?
- In an emergency, time counts. In a disaster, time becomes even more crucial.
- During disasters it is imperative that your local emergency services providers know who needs their assistance.

Your information will be kept confidential and will only be used for emergency planning and response efforts.

Your participation is voluntary...but we hope that you will help us...to help you!

Please complete the form and mail it to the Lebanon County Department of Emergency Services:

1805 Cornwall RoadLebanon,
PA 17042
(717) 272-7621
EM@lcdes.org



Detach this end of paper and mail to LCDES.

Name:

Address:

City:

Zip Code:

Municipality:

Phone Number:

Mobile:

Home:

Emergency Contact Name:

Emergency Contact Phone Number:

Please check all that apply.

Communication Needs

☐ English is not my primary language.

I speak:

☐ I have a hearing impairment

☐ I have low vision/blindness

☐ I do not speak / have difficulty speaking

☐ I need access to auxiliary communication services/devices

Services/Supports/Self-Determination

☐ I have mental health needs

☐ I have developmental disability needs

☐ I have a cognitive impairment