**Portage County Special Needs Registration Form**
**HIPAA Waiver must be signed and included with submission of registry form**
**Questions or Comments 330-296-5100 (non-emergency)**

| **PERSONAL INFORMATION** | | | Date of Application | |
|---|---|---|---|---|
| **Last Name** | **First Name** | **Middle Intitial** | **Date of Birth** | **Sex (circle)** |
| | | | / / | Male / Female |
| Address (include city, state and zip code) | | | Home Phone | Cell Phone |
| Email | | Veteran? Y / N | TTY/Video Phone | Alternate Phone |

| **Living Situation** | **Residence Type** | **Race/Ethnic Group** | **Language** |
|---|---|---|---|
| _____ Alone<br>_____ With Spouse<br>_____ Other<br>_____ Residential Setting (Group Home) | _____ Private Home<br>_____ Apt/Condo<br>_____ Mobile Home | _____ African/Amer<br>_____ Caucasian<br>_____ Hispanic<br>_____ Asian/Pacific Islander<br>_____ American Indian | _____ Arabic _____ French _____ Korean<br>_____Tagalong _____ Chinese _____ German<br>_____ Russian _____ Vietnamese<br>_____ English _____ Italian _____ Spanish |

| **EMERGENCY CONTACTS** | | | |
|---|---|---|---|
| Primary Emergency Contact | Relationship | Home Phone | Work Phone<br>Cell Phone |
| Address (include city, state and zip code | | Email Address | |
| Secondary Emergency Contact | Relationship | Home Phone | Work Phone<br>Cell Phone |
| Address (include city, state and zip code | | Email Address | |

| **MEDICAL INFORMATION** | |
|---|---|
| _____ Requires 24 hr care | |
| **Requires Life-Sustaining Equipement** | **Communication Impairments** |
| _____Oxygen _____Ventilator _____Feeding Pump _____Dialysis<br>_____Suction _____Nebulizer _____Other (Describe Below) | _____ Speech Impaired _____ Hard of Hearing<br>_____ Deaf _____ Forgetful |
| **Requires Life-Sustaining Medication** | **Sight Impairments** |
| _____ Cardiac _____ Respiratory _____ Diabetes _____Other (Describe Below) | _____ Blind _____ Other (Describe Below) |
| **Mobility Impairments**<br>_____ Bedridden _____ Wheelchair _____ Walker _____ Cane | _____Cardiac History (Describe below)<br>_____Respiratory History (Describe below) |

Other Pertinent Information: _____
_____
_____

| | |
|---|---|
| Dependencies | Medications |
| Physcial Conditions | Allergies |
| Medical Conditions | Other Medical Notes |

| **MEDICAL PROVIDERS** | | | |
|---|---|---|---|
| Oxygen Provider | Phone | Home Health Agency | Phone |
| Primary Physican | Phone | Pharmary | Phone |