"Are You Ok?" Program
Application

Greenfield Are You OK Committee
Greenfield Town Hall
PO Box 10
Greenfield Center, NY 12833
Phone 518-893-7432
Fax 518-893-2460

_____ _____ _____

Last Name First Name Middle

_____ _____ _____ _____

Street Address Apt. # Town Zip

Home Phone:_____ **Do You have a Hard Wired Phone?:** ☐ Yes ☐ No

Phone Provider i.e. Verizon, Time Warner, etc.: _____

Cell Phone _____ **Email:** _____

Mailing Address (if different from above): _____

Sex: ☐ Male ☐ Female **Weight**____lbs. **Height:**____ft.____in. **Date of Birth**__/__/____

Residence Type ☐ Private Home ☐ Duplex ☐ Apartment/Condo

Location of Bedroom (including floor number, front or back and let or right side of house):

_____

Homeowner (if different from above): Name: _____

Address:_____ Phone # _____

Are you a full time resident of Greenfield: ☐ Yes ☐ No

If No, dates residing in the Town of Greenfield: from_____ to_____

Do you have a generator: ☐ Yes ☐ No

Evacuation Info: Do you require evacuation assistance? ☐ Yes ☐ No

If yes, I am:

☐ Ambulatory ☐ Ambulatory w/Assistance ☐ Wheelchair Dependent ☐ Confined to Bed

Transportation: Do you require transportation? ☐ Yes ☐ No

If Yes, I require;

☐ Special transportation ☐ Vehicle with lift gate ☐ Vehicle equipped for stretcher

Ambulance: ☐ For Basic Life Support ☐ For Advanced Life Support

Medications:

Do any of your medications require refrigeration? ☐ Yes ☐ No

Medications are: ☐ Intravenous ☐ Injection ☐ By mouth

Do you have a medication list? ☐ Yes ☐ No

If yes – kept where? _____

Do you have a Vial or Life/File of Life? ☐ Yes ☐ No

If yes – kept where? _____

Locations where medicines are kept:

Daily (if in pill container) _____

Actual prescription bottles _____

You may attach a medication list to this form if you wish.

Do you have allergies? ☐ Yes ☐ No

If yes, please list allergies: _____

Disability/Condition (check all that apply):

☐ Visually impaired ☐ Hearing impaired ☐ Do you have a hearing/seeing eye dog?

Require Translator (language): _____

Breathing Problems: ☐ COPD ☐ Asthma ☐ Emphysema

Require Oxygen? ☐ Occasional or ☐ Continuous

Oxygen Supplier _____ Phone No. _____

☐ Mental Disability ☐ Dementia ☐ Psychiatric Diagnosis ☐ Cardiac

☐ Dialysis ☐ Seizures ☐ Diabetes ☐ Stroke ☐ Other _____

Special Equipment: Is electricity required? ☐ Yes ☐ No

☐ Oxygen ☐ Dialysis ☐ Intravenous ☐ Wheelchair ☐ Defibrillator

☐ Walker/Cane Crutches ☐ Suction ☐ Diabetic Monitoring Equipment

☐ Other _____

Emergency Contacts:

Family (not residing with you): Name: _____

Phone _____ Cell Phone _____

Address: _____

Neighbor: Name: _____

Phone _____ Cell Phone _____

Address: _____

Caregiver: Name: _____

Phone _____ Cell Phone _____

Address: _____

Primary Physician Name: _____

Phone _____

Address: _____

* * * * * * * * * * * * * *

I certify that this information is correct and to the best of my knowledge and that participation in this program is voluntary. I understand that based on the information provided to me, I may or may not be assigned to a special needs unit. The Town of Greenfield is under no obligation to provide any services as a result of my submission of this form. I understand that the assistance will be provided only for the duration of the emergency and that I should make alternate arrangements in advance in case I am not able to return to my home.

I understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers, transportation agencies, and others, as necessary to provide care and disclose information to respond to my needs. I hereby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue.

Signature of Applicant: _____ Date _____

Signature of Legal Guardian _____ Date _____

Signature of Person completing this form other than applicant or legal guardian:

_____ _____ _____

Signature Relationship to applicant Date

Please do not write below this line

Fire District _____ Evacuation Level _____ Reviewed by _____