

APPLICATION TO REGISTER FOR THE SPECIAL NEEDS PROGRAM

The Patient is responsible for completing, signing and returning this **two-page** form to:
Lee County Emergency Management, Attention Debbie Quimby, P.O. Box 398, Fort Myers, FL 33902-0398
FOR INFORMATION CALL (239) 533-3640 / FAX # (239) 477-3636

Registration officially turns off when Lee County enters into the 5-day forecast cone.

SPECIAL NEEDS APPLICANT – Please complete the following shelter registration (PLEASE PRINT):

Last Name: First: Date of Birth:

Primary language: Height: Weight:

I live alone; I live with relatives; I live with caregiver(s); other – explain below

Address: Street: City: Zip:

Mailing Address: Subdivision Name:

Home Phone: Cell/Alternate Phone:

Caregiver's Name: Phone:

Emergency contact, other than your Caregiver:

Relationship: Phone Number:

Print Physician's Name: Phone Number:

I live in a manufactured home, mobile home or trailer

Shelter & Transportation Needs: (please check one box only)

Have Transportation – Need Shelter Only

- Special Care Shelter only - I have a ride/driving self
 Hospital Shelter only - I have a ride/driving self

Need Transportation & Shelter

- Transportation & Special Care Shelter
 Transportation & Hospital Shelter
 Transportation only to Emergency Public Shelter

Transportation Requirements:

- I will walk to bus pickup point
 I can walk limited distances only
 I have a service animal
 I am ambulatory with assistive device
 I am wheelchair/scooter bound-need handicap bus
 I am bedridden-require ambulance transport

Personal Health Concern:

- Visually impaired
 Hearing impaired
 Developmental/Cognitive impairment
 Bowel/bladder incontinent
 Unstable hemodialysis
 Need help managing own daily medications

Mobility/Special Equipment: (please check all that apply to you)

- Cane Walker Wheelchair Scooter (electric)
 Amputee (limb) Paraplegic Quadriplegic Service animal
 Nebulizer (breathing machine) CPAP/Bi-PAP Feeding tube, blender, liquid food

I have allergies (details below)

I have a pet (Service animals only are permitted at Special Care Shelters, no others are allowed)

MEDICATION NOTE: If evacuated, it is important that you bring with you at least a two-week (preferably a one-month) supply of all your medications in their original containers

You must have a Caregiver if assigned to either a Special Care Shelter or a Hospital.

Recommended Level of Care – check all that apply

The physician in charge of the Dept. of Health will review and assign to the appropriate shelter based on stated criteria.

Special Care Shelter for the Following Conditions:

- | | |
|--|--|
| <input type="checkbox"/> Walks less than 100 feet without assistive device | <input type="checkbox"/> Terminally ill (Hospice shelter as first preference) |
| <input type="checkbox"/> Wheelchair bound | <input type="checkbox"/> Requires constant, reliable source of electricity |
| <input type="checkbox"/> Oxygen dependent | <input type="checkbox"/> Chronic wounds/ulcers requiring dressing changes |
| <input type="checkbox"/> Ostomy, foley or external catheter, self-catheter (circle) | <input type="checkbox"/> Medical equipment required at least 4 times daily (ex: IV pump, nebulizer) Specify below: |
| <input type="checkbox"/> Recent hospital discharge (physician/patient judgment) | <input type="checkbox"/> Requires assistance or supervision with medications, IM or IV injections |
| <input type="checkbox"/> Transfers with assistance (but weighs less than 300 lbs) | <input type="checkbox"/> Other (give details below): |
| <input type="checkbox"/> Home peritoneal dialysis | |
| <input type="checkbox"/> Unable to make independent judgments for own welfare i.e. Alzheimer's, dementia, etc. (specify below) | |

Hospital Care for the Following Conditions:

Your doctor must send us written authorization before you can be sheltered in a hospital

- Bedridden
- Weighs more than 300 lbs and requires personnel or mechanical asst with transfers
- Ventilator dependent-respiratory status: _____
- Combative, prone to wander, violent tendencies
- Medical equipment required continuously other than oxygen (specify below)

NOTE TO DOCTOR:

A copy of your letter/script (separate from this form) must be dated current year & included with this application stating patient must be evacuated to a hospital in event of hurricane. Patient takes original with him/her if evacuated.

Suggested/Preferred Hospital:

Doctor's script attached

Additional medical information:

Records relating to the registration of special needs citizens are exempt from the provision of S.119.07(1), Florida Statutes.

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet accompanying this request and I understand that there are limitations on the services and levels of care that are available.

I understand that the Special Care Shelter will be open only for the duration of the emergency. I need to make plans in advance for alternate living arrangements in case my home is destroyed or if I am not able to return to my home for an extended period of time.

I understand that I may or may not be assigned to a Special Care Shelter based on the information I have provided, available space at those facilities, and the criteria to be met for the shelter residents.

I also understand that I will be responsible for any charges and costs associated with hospital, medical facility care and/or medical transportation.

I hereby grant permission to medical providers, transportation agencies and others, to provide care and respond to my needs, and for the disclosure of any information necessary to do so. I also grant permission to emergency response agencies to enter my residence for the purpose of emergency search and rescue, and authorize the release of information necessary for these agencies to perform these services.

In an effort to ensure the safety of all shelter residents, a background screen will be run on all people evacuating to the Special Care Shelter, including the caretakers. I understand this registration is voluntary and do hereby request to be registered in the Lee County Special Needs Program.

Client Signature:

Date:

Print Client Name:

Witness signature:

Date:

(If unable to sign, please have your Representative sign above)