

**Special Needs Program Annual Application**

Complete one application per person. Please print clearly. You may be contacted by a member of the Emergency Services staff to review your application and answer any questions you may have.

**APPLICANT INFORMATION**

SS#	First Name:	Middle Initial:	Last Name:
Date of Birth: (Month-Day-Year)	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Physical Address: (Include Lot or Apt. #)		City: Vero Beach <input type="checkbox"/> Sebastian <input type="checkbox"/> Fellsmere <input type="checkbox"/>	
State: FL	Zip Code:	Primary Phone:	Secondary Phone:
E-Mail Address:			

**RESIDENCE**

Private Home <input type="checkbox"/>	Apartment <input type="checkbox"/>	Condo <input type="checkbox"/>	<b>Manufactured/Mobile Home</b> <input type="checkbox"/>
Name of Complex, Subdivision, or Development:			
Are you a full time resident of Indian River County? Yes <input type="checkbox"/> No <input type="checkbox"/>			

**LOCAL MAILING ADDRESS (if different from address above)**

Street Address:	City:	State:	Zip Code:
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**EMERGENCY CONTACT INFORMATION**

Primary Contact:	Relationship:	Phone:
Secondary Contact:	Relationship:	Phone:

**EVACUATION INFORMATION**

**TRANSPORTATION – Do you need transportation to a shelter? (please select one):**  
 1.  Yes, I need transportation.  No, I will transport myself.

2. **If you answered yes above, what kind of vehicle do you require? (please select one):**  
 Regular vehicle  Wheelchair van  Stretcher vehicle (ambulance)

**CAREGIVER** - If assistance is needed, each applicant is **REQUIRED** to be accompanied by one caregiver. **NAME:** \_\_\_\_\_ Phone: \_\_\_\_\_

**PETS** – I need to register for the Humane Society's program to care for my pet(s) while I am at the Special Needs Shelter. **YES: I have a Dog(s)**  **and/or Cat(s)**

**MEDICAL INFORMATION**

Are you a Hospice patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of home health care agency, if applicable: _____ Phone: _____

MEDICAL INFORMATION continued	
Name of Pharmacy:	Phone:
Name of Primary Physician:	Phone:
Name of oxygen provider, if applicable:	Phone:
ALLERGIES	
<b>Allergies:</b> Are you allergic or sensitive to any medication(s)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please explain which medications and what the reaction was:	
MOBILITY:	RESPIRATORY SUPPORT:
<input type="checkbox"/> I can walk <b>without</b> assistance <input type="checkbox"/> I walk <b>with</b> assistance <input type="checkbox"/> I use a cane <input type="checkbox"/> I use a walker <input type="checkbox"/> I use a <b>standard</b> (non- electric) wheelchair <input type="checkbox"/> I use an <b>motorized</b> wheelchair/scooter <input type="checkbox"/> I am bedridden (require stretcher) <input type="checkbox"/> I use a Hoyer lift	<input type="checkbox"/> I am oxygen dependent and understand that I must bring an ample supply of oxygen to get me to and from the shelter. _____ As Needed _____ 24/7 _____ Overnight <input type="checkbox"/> I use a O2 Concentrator <input type="checkbox"/> I use a Nebulizer <input type="checkbox"/> I use a CPAP <input type="checkbox"/> I use a Ventilator <input type="checkbox"/> I use a Suction Machine
GENERAL MEDICATION CONDITIONS:	
<input type="checkbox"/> I use <b>Insulin</b> for <b><u>DIABETES</u></b> <input type="checkbox"/> I use <b>Oral Medication</b> for <b><u>DIABETES</u></b>	<input type="checkbox"/> Severe arthritis <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart condition <input type="checkbox"/> Blind/Vision impaired <input type="checkbox"/> Deaf/Hearing impaired <input type="checkbox"/> Service animal <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheterized <input type="checkbox"/> Ostomy <input type="checkbox"/> Feeding tube <input type="checkbox"/> <b>Alzheimer's/Other Dementias (Caregiver REQUIRED)</b> <input type="checkbox"/> Electric Dependent (O2, CPAP) <input type="checkbox"/> Other:
<input type="checkbox"/> Paralysis <input type="checkbox"/> Complete <input type="checkbox"/> Partial	
<input type="checkbox"/> Dialysis <input type="checkbox"/> Home Dialysis <input type="checkbox"/> Facility Dialysis Number of times dialyzed per week: _____ Name of dialysis center:	
<input type="checkbox"/> Open wounds that require dressing changes.	Times per day:
<input type="checkbox"/> Medications that require refrigeration?	

<b>MEDICATIONS:</b> (Attach a separate sheet if necessary)					
<b>Prescription Medications</b>			<b>Over-the-counter (OTC) medications</b>		
Rx Name	Dose	How Often	OTC Name	Dose	How Often

**SPECIAL NOTES**

As a special needs shelter evacuee, I am entitled to pre-authorize emergency response personnel to enter my home during search and rescue operations, if necessary, to assure my safety and welfare following a disaster as defined in Florida Statutes 252.34.

Yes, I do pre-authorize.                       No, I will not pre-authorize.

I understand that the Special Needs Shelter will not be air conditioned if emergency power is required.

I understand that I need to bring with me all medications, in marked bottles, and all medical supplies I use for my care for up to 14-days (two weeks).

I understand that I must bring my own bedding. The Special Needs Shelter will not supply cots or other bedding.

Part of my emergency plan includes designating alternate living arrangements (home of friend or relative, etc.) in the event my home is severely damaged and I am unable to return.  
***My alternate plan is to temporarily reside at the following location:***

I understand that once this public shelter has been closed following the emergency event, it will be my responsibility to either return home or seek other living arrangements.

**\*\*\*READ AND SIGN\*\*\*READ AND SIGN\*\*\*READ AND SIGN\*\*\*READ AND SIGN\*\*\***

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Department of Emergency Services will determine which emergency evacuation assistance, if any, this program may be able to provide. Further, I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**APPLICANT REPRESENTATIVE**

If the person completing this form is not the applicant, please answer the following:

Name: \_\_\_\_\_ Relationship/Agency: \_\_\_\_\_

Phone:(      )      Applicant has been notified of this registration: Yes  No

**OFFICIAL USE ONLY**

Reviewed By: _____	Date: _____	Category: _____	Sector #: _____
Applicant Contacted: _____	Pre-Registered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Stay: <input type="checkbox"/> Patient <input type="checkbox"/> Caregiver	
Type of Shelter: <input type="checkbox"/> Regular <input type="checkbox"/> SNS <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice	<input type="checkbox"/> Patient/Caregiver		

**\*\*\*Return Application to\*\*\***  
IRC Dept. of Emergency Services (ATTN: SNS)  
4225 43<sup>rd</sup> Avenue  
Vero Beach, FL 32967