2018 Special Needs Registry Application

http://www.monroecounty-fl.gov/index.aspx?nid=148

Individuals are eligible to be registered with the Special Need Registry if during periods of evacuation or emergency, they require sheltering assistance, due to physical impairment, mental impairment, cognitive impairment, or sensory disabilities, and are not served in or by a residential facility program. Eligible clients are required to complete and sign this application, the HIPAA Disclosure of Information, and HIPAA Privacy Act forms before they are placed on the Special Needs Registry.

Primary Language: English: ____ Spanish: ____ Other(specify): _____

Last Name: _____ First: _____ Middle Initial: _____ Sex: M ___ F ___
Social Security#: _____-_____-_____ DOB: __/__/____ Weight: _____ Height: ____Feet ____Inches
Medicaid #: _____ Medicare#: _____ Insurance & #:_____
Physical Address: _____ City: _____ Nearest Mile Marker:_____
Mailing Address (if different): _____City: _____ Zip: _____
Primary Contact Number: _____-_____-_____ ☐ Home ☐ Cell ☐ Work ☐ Other _____
Additional Contact Number(s):____-____-_____, ____-____-_____, ____-____-_____
If married: Name of Spouse: _____ Spouse's Contact Number: _____

Is Your Spouse Also Listed on the Special Needs Registry? ☐ YES ☐ NO

Residence Type – (please check one) ☐ Single Family Home ☐ Apartment ☐ Condo ☐ Mobile Home /RV ☐ Boat/Live-Aboard ☐ Other – (please Specify):_____ ☐ Year-round resident ☐ Seasonal Resident If Seasonal, specify months you live here: _____	Pet(s) Y ☐ N ☐? Number: _____ Type(s): _____ Vaccinations up to Date: Y ☐ N ☐? Do You Need Monroe County To Transport You to a Shelter?: Y ☐ N ☐. Category Storm to Transport: ☐ Cat 1-2 ☐ Cat 3-5 ☐ All	Are You Currently Receiving Home Health Services? Y ☐ N ☐ If yes, Name of Agency Providing Services: _____ Your Physician's Name: _____ Physician's Phone Number: _____-_____-_____

If you have a required caregiver, please list his/her name and phone number.

Name: _____ Phone number: _____-_____-_____

You **must** give name & phone number of a neighbor or friend that we may use for an alternate contact. (This person must live in your area or be aware of your whereabouts and must be aware that they are listed as an alternate contact.)

Name _____ Phone _____

Name _____ Phone _____

Emergency contact (if different from above)
Name _____ Phone _____

Name _____ Phone _____

Please Complete the following information:

Number of care givers/ family members accompanying client to the Shelter:_____
Caregiver/family member **names**: _____

Are you Medically Dependent On Electricity?	**Are you Oxygen Dependent?**
☐ O2 Concentrator ☐ Feeding Pump	☐ 24 hour ☐ Only Overnight ☐ Nebulizer ☐ CPAP
☐ Suction ☐ Respirator	O2 Type: _____ Assistance needed? Y ☐ N ☐

☐ Need Assistance with Medication ☐ Need Assistance with Feeding ☐ Need assistance with Communication ☐ Need Assistance with Wound Care ☐ Need assistance with Catheter	☐ Mental Health Problems ☐ Anxiety/Depression ☐ Cognitive Impairment ☐ Alzheimer's/Dementia ***Early*** ☐ ***Middle*** ☐ ***Late*** ☐	☐ Vision Loss/ Impairment ☐ Hearing Loss/ Impairment ☐ Speech Impairment
☐ Incontinence ☐ Insulin Dependent ☐ Need Assistance with Insulin ☐ Dialysis Dependent ☐ Open Wounds ☐ Decubitus ☐ Other/Comments: _____ _____	Can You Sit up and Ride in a Bus or Van? Y ☐ N ☐ ☐ Ambulatory ☐ Ambulatory with Assistance ☐ Wheelchair ☐ Wheelchair Bound ☐ Bedridden Transportation Needs: ☐ Wheelchair Accessible Van ☐ Car ☐ Bus ☐ Ambulance ONLY ☐ Other: _____	Do you have a "Do Not Resuscitate Order" (DNR) in place? Y ☐ N ☐ *If yes, please attach a copy and be aware that you will need to bring the DNR to the shelter with you.*
☐ Heart Condition ☐ Back injury ☐ Arthritis ☐ Pregnancy ☐ High-Risk Pregnancy	☐ Do you have a Trained Service Animal? Type of Animal: _____ Name of Animal: _____ What work or task has the animal been trained to perform? _____	

Last Name: _____ First: _____ Middle Initial: _____

The information contained herein is true and correct to the best of my knowledge. I understand that assistance will be provided only for the duration of the emergency and that I should make alternative arrangements, in advance, in the event that I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital and/or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others, as necessary, to provide care, and disclose any information necessary to respond to my needs. I also grant permission to emergency personnel to enter my home following and emergency, if deemed necessary by proper authorities. I understand that this registration is voluntary and hereby request enrollment on the Special Needs Registry. I understand that all information given will be held in the strictest confidence and will be used for emergency purposes only.

☐ I decline registration.

☐ I have received the notice of Protected Health Information (SS Form 2), Signed and Returned the Receipt of Privacy Practices (SS Form 1), Signed and Returned the Disclosure of Information Form, and Signed and Returned the Pet Agreement (if Applicable).

X_____ Date _____
Signature of Client Date of Signature

Please return completed form to the following address:

Monroe County Special Needs Registry
1100 Simonton Street Room 1-186
Key West, FL 33040

**********FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE **********
Entered into EVAC by: _____ Date:_____
Entered into TRPZE by: _____ Date: _____