SPECIAL NEEDS REGISTRY FORM

2017 Special Needs Registry Application

Individuals are eligible to be enrolled on the Special Needs Registry, if during periods of evacuation or emergency they require sheltering assistance due to physical, mental, cognitive, or sensory impairment, and are not served in or by a residential facility program. Eligible individuals are required to complete and sign this application and acknowledge their receipt of a HIPAA Disclosure of Information form and HIPAA Privacy Act form before they are placed on the registry.

Last Name _____ First _____ Middle Initial _____ Sex M ___ F ___

Social Security# ___-___-_____ DOB: ____/____/_____ Medicaid # _____ Medicare# _____

Physical Address _____ Key _____ Nearest Mile Marker _____

Mailing Address (if different) _____City_____ Zip _____

Home Phone#_____ *If you do not have a phone, you must list a neighbor's phone number that we may use to contact you.*

Primary Language: English ____ Spanish ____ Creole _____ Other _____

If married: Name of Spouse _____Is Spouse registered? Y____N____

Residence type (please check one): Single family home/Duplex _____ Apartment _____ Boat _____

Condo _____ Campground/RV _____ Mobile Home _____ Other _____

Number of Pets in home: Dog _____ Cat _____ Other (type & #) _____
NOTE: Pets of Special Needs Registry clients are eligible and if pre-registered, will be taken to a Pet-Friendly Shelter. These arrangements must be made in advance of the client's pick-up

Do you need Monroe County Transit (MCT) to transport you to a shelter? Y_____ N _____

Category storm you need transportation for 1 & 2 _____ 3 or higher _____ All _____

Are you a Year Round Resident _____ Seasonal Resident _____ List months you are in county: _____

Can you sit up and ride in a bus or van? Y _____ N_____ Do you need a wheelchair lift? Y ____ N ____

Are you receiving home health care? Y _____ N _____ Name of agency _____

If you have a required caregiver, please list their name and phone number.

Name _____ Phone number _____

Total number of people that will accompany you to a shelter _____

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 & must be aware that they are listed as an alternate contact!

Name _____ Phone _____

Emergency contact (if different from above)

Name _____ Phone _____

**********FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE **********

Referring Agency Name: _____
Address & Phone Number: _____

Height _____Feet _____Inches **Weight _____**

Check all that apply

About your condition:		**Are you dependent on any of the following:**	
No Disabilities		*Catheters*	
Alzheimer's – Note Stage		*Electricity*	
Ameliorating Lateral Sclerosis ALS		*NG tube/CV infusion site/tracheostomy*	
Back Injury		Insulin	
Blind, Hearing or Speech Impaired		*I.V. Medication*	
Cerebral Palsy		*Oxygen*	
Colostomy or Ileostomy - Specify		*Respirator*	
Contagious Disease - Specify		Incontinence	
Epilepsy / Other Seizures - Specify		Walker / Cane / Crutches	
Fractured Bones with Pin Care		Wheelchair on occasion	
Full Paralysis		Ambulatory(can get around on your own)	
Heart Condition		Ambulatory with assistance	
High Blood Pressure		*Non-Ambulatory (bedridden)*	
Mental Illness - Specify		*Wheelchair bound*	
Special Diet - Specify			
Pregnant in 7th month or More		*Dialysis -no dialysis available at shelter*	
Severe Arthritis		*Terminal Condition*	
Other Condition - Specify			

Medications:

Name of Medication	*Dosage*	*Name of Medication*	*Dosage*

Do you have a "Do Not Resuscitate Order" in place? Yes _____ No _____ *If yes, please attach a copy*

Is shelter assistance needed for (circle all that apply):

*Communications *Feeding *Dressing Changes *Medication

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 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 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 an 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 emergencies purposes only.

☐ I decline registration.

☐ I have received the notice of HIPAA privacy practices.

X_____ Date _____

Signature of Client Date of Signature

Please return completed form to the following address:

Monroe County Special Needs Registry
1100 Simonton Street, Suite 1-180
Key West, FL 33040

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Entered into System _____ Entered into Trapeze _____