Broward County – Special Needs Shelter and Evacuation Transportation Assistance Application

Thank you for your interest in the Broward County Adult Special Needs Shelter. Please understand that the shelter is a place of refuge of last resort from dangerous weather or other emergencies. While basic services such as food, electricity, and medical supervision will be provided, clients and caregivers must provide supplemental food and all medications for the first five (5) days. **Please remember**: Cots are provided for clients. Cots may not be available for caregivers.

CLIENT CONTACT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

PHYSICAL ADDRESS: _____ Bldg. #: _____ Apt/Lot #: _____

DEVELOPMENT/SUBDIVISION: _____ City: _____ ZIP: _____

RESIDENCE TYPE: Single Family Apartment / What floor? _____ Condo / What floor? _____
Mobile/Manufactured Recreational Vehicle Boat

MAILING ADDRESS (if different than above): _____

LIVING SITUATION: Alone Relative Other _____

D.O.B. (Required) / / ____ AGE: _____ Gender: Male Female Other No response

DO YOU EXCEED 450 POUNDS? Yes No

PRIMARY PHONE#: _____ SECONDARY PHONE #: _____ E-MAIL _____

IS YOUR PRIMARY TELEPHONE TTY/TTD (Teletype): Yes No

WHAT IS YOUR PRIMARY LANGUAGE? _____ RACE/ETHNICITY _____

EMERGENCY CONTACT INFORMATION

1. NAME: _____ RELATIONSHIP _____

   PRIMARY PHONE# _____ SECONDARY PHONE# _____ E-MAIL _____

   CHECKING THIS BOX ALLOW MEDICAL INFORMATION TO BE SHARED WITH THIS INDIVIDUAL

2. NAME: _____ RELATIONSHIP _____

   PRIMARY PHONE# _____ SECONDARY PHONE# _____ E-MAIL

   CHECKING THIS BOX ALLOW MEDICAL INFORMATION TO BE SHARED WITH THIS INDIVIDUAL

AT LEAST ONE EMERGENCY CONTACT MUST BE PROVIDED

Last Name:_____ **First Name**:_____ **Middle Initial** _____

EVACUATION TRANSPORTATION ASSISTANCE

Are you registered with TOPS? Yes ( ) No ( ), if yes what is your PIN number? _____

1. Do you require transportation to a shelter? ( ) YES ( ) NO

2. **MOBILITY AID: Please check off ALL that apply to you:**

( ) Can walk without help ( ) Cane ( ) Crutches ( ) Walker ( ) Electric Scooter

( ) Manual Wheelchair ( ) Electric Wheelchair

( ) Confined to a bed ( ) Sleep on hospital bed at home ( ) Use a special lift to get out of bed

3. Do you require help when walking? Yes ( ) No ( )

4. If you use a Wheelchair, do you require help transferring? Yes ( ) No ( )

5. Check the one that applies to you:
   a. I cannot get outside my home
   b. I can get to the curb outside my home

6. Blind or Vision loss? Yes ( ) No ( )

7. Do you have a service animal? Yes ( ) No ( ), if yes what kind _____

8. Are you able to sleep on a portable medical cot (see information below)? ( ) Yes ( ) No

1. 18 inches high (wheelchair height)
2. 32 inches wide X 80 inches long

9. Will anyone be coming with you to the shelter? Yes ( ) No ( )
   If Yes, name/relationship: _____
   Total number of persons to be picked up from this address? ____
   Number of persons requiring wheelchair ____

Last Name: _____ **First Name:** _____ **Middle Initial** _____

MEDICAL SUPPORT INFORMATION

PRIMARY DOCTOR: PHONE: _____

HOME HEALTH AGENCY: PHONE: _____

HOSPICE PROVIDER: _____ PHONE: _____

HOME MEDICAL EQUIPMENT PROVIDER: PHONE: _____

DIALYSIS CENTER: _____ PHONE: _____

OXYGEN SUPPLIER: _____ PHONE: _____

SPECIAL NEEDS (check all that apply)

Electrical Needs

Apnea Monitor
Bi-Pap or C-Pap Machine
Cardiac (Heart) Monitor
Feeding Tube Pump
IV Medication: Please specify:

Medication requiring refrigeration

Nebulizer

Oxygen Dependent:
24 hours
Overnight
Concentrator
Portable Tank
Liter Flow per Minute

_____

Suction Pump
Ventilator/Respirator *(A machine that moves air in and out of your lungs because you cannot breathe on your own)*

Assistance With Daily Living

Going to the toilet

Taking medications

Feeding/Eating

Walking more than 50 ft.

Getting out of bed

Dressing

Specialized Equipment

Feeding Tube

Foley Catheter for urine

IV Equipment

Tracheostomy Tube

Other _____

_____

Last Name: _____ **First Name:** _____ **Middle Initial** _____

Psychological Conditions	Neurologic/Sensory	Special Care
Alzheimer's/ Dementia (requires caregiver) Anxiety Autism Conduct Disorder Depression Obsessive Compulsive Disorder Psychosis controlled with medication Psychosis not controlled with medication Other psychiatric diagnosis: _____	Blind / Visually Impaired Deaf / Hearing Impaired Difficulty swallowing foods or liquids Seizures controlled with medication Seizures not controlled with medication	Foley Catheter Open wounds/ bed sores Wound V.A.C. Incontinent Urine Stool Ostomy Adult Diapers Tracheostomy Dialysis: #_____days per week Hemodialysis ( ) Peritoneal dialysis ( ) Special Diet _____ _____

DIAGNOSIS (Check all that apply)	
Chronic but Stable Illness	Aphasia (Difficulty communicating) Asthma controlled with medications not controlled with medication Heart Disease controlled with medication not controlled with medication Cancer Please specify: _____ Contagious Disease Please specify: _____ Diabetes/ high blood sugar Insulin Dependent Fractured Bones (Pin care/dressing changes) Hemophilia Infection Please specify: _____ Lung Disease (COPD / Emphysema /Bronchitis) MRSA Neurological Deficit Please specify: _____ Renal (Kidney) Disease Sickle Cell Anemia Skin Rash Please specify: _____ Stroke
Chronic but Stable Illness With Mobility Impairment	Cerebral Palsy Frail/elderly Wheelchair Bound due to Chronic Illness (Such as: ALS, Cerebral Vascular Accident (stroke), Multiple Sclerosis, Muscular Dystrophy, etc.)
Electricity Dependent	Electric Medical Equipment

Last Name: _____ **First Name:** _____ **Middle Initial** _____

List any other medical problems:	_____ _____

Allergies to medications or foods: YES or NO, If yes, Please specify:

_____

_____

PRESCRIPTION MEDICATION (please attach list if necessary)

Medication Name:	**Dose:**	**# of times per day:**
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5.	5. _____	5. _____
6. _____	6. _____	6. _____
7. _____	7. _____	7. _____
8. _____	8. _____	8. _____
9. _____	9. _____	9. _____
10. _____	10. _____	10. _____

Last Name:_____ **First Name:**_____ **Middle Initial** _____

Broward County Special Needs Emergency Shelter and Evacuation Transportation Assistance Application

STATEMENT OF UNDERSTANDING AND SIGNATURE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The information contained herein is true and correct to the best of my knowledge. I understand that if accepted, assistance will be provided only for the duration of the emergency, and that alternative arrangements should be made in advance in case I am unable to return to my home.

I understand that based on this application and the data I have provided, Florida Health in Broward County, along with the Broward County Emergency Management Division, will determine which sheltering and emergency evacuation assistance, if any, this program may be able to provide.

I understand that this registration is voluntary and hereby request registration in the Broward County Special Needs Shelter and Evacuation Transportation Assistance Program.

By signing this form I give my authorization for medical information contained herein to be released to the Broward County Human Services Department, Florida Health in Broward County, Memorial Health Care System, Holy Cross Hospital, Broward Health, and other hospitals, medical facilities and providers, the Broward County Transit Division, and the Broward County Emergency Management Division, for the purpose of evaluating my needs and providing transportation and sheltering. I give authorization for Broward County to resend page 2 of my application to the physician listed on an annual basis for update. I understand that changes to the information submitted requires completion of a new application and re-submittal. I further understand that if Broward County requests updated information or cannot contact me due to changes in my information they may remove me from the registry. This authorization shall remain in effect for 12 months from the date of signature.

With the exception of e-mail addresses, records relating to registration of persons requiring functional needs support are exempt from the provisions of F. S. 119.07 (1), Public Records Law. Except as otherwise provided by this authorization, the information you provide will be kept confidential.

Applicant/Patient Full Legal Name

(PRINT):_____

Applicant/Patient Signature: _____ Date:_____

If this authorization is signed by an individual's personal representative, or health care provider, on behalf of the individual, please complete the following:

Personal Representative's Full Legal Name

(PRINT):_____Relationship _____

Contact Information (include telephone #)

Personal Representative's Signature:

_____Date:_____

Completed applications must be mailed to:

Broward Emergency Management Division
Attn: Special Needs Registry
201 NW 84th Avenue Plantation, FL 33324
954/831-3902

If you have questions about this authorization, or to revoke this authorization prior to the expiration date or event, you must submit a written request to the above address.