

PLEASE PROVIDE US WITH SOME INFORMATION ABOUT YOURSELF

NAME: _____ / _____ / _____			
	Last	First	MI
			DATE OF BIRTH (mm/dd/yyyy)
HEIGHT: _____	WEIGHT: _____	DO YOU LIVE ALONE? Y or N	DO YOU HAVE A CAREGIVER? Y or N
DO YOU LIVE IN A MOBILE/MODULAR HOME? Y or N		DO YOU HAVE PETS? Y or N	
# OF PETS: _____	TYPE OF PETS: _____	HAVE YOU MADE PLANS FOR YOUR PETS? Y or N	
TELEPHONE# () _____ - _____		TTD Y or N	PRIMARY LANGUAGE _____
WILL SOMEONE BE ACCOMPANYING YOU TO A SHELTER? Y or N			
IF YES, CAN THIS PERSON PROVIDE YOU WITH (SEE BELOW)			
TOTAL CARE Y or N		NEEDS HELP WITH CARE Y or N	IS UNABLE TO PROVIDE CARE Y or N
PHYSICAL ADDRESS:			
House Number		Street Name	Apt or Lot #
MAILING ADDRESS (If Different): _____			
DO YOU LIVE WEST OF US HIGHWAY 19		City	Zip Code -
Y or N		Subdivision/Mobile Home Park Name	
ANY SPECIAL INSTRUCTIONS? _____			

PLEASE PROVIDE US WITH THESE IMPORTANT PHONE NUMBERS

HOME HEALTH AGENCY:		Telephone# _____
PHYSICIAN:		Telephone# _____
OXYGEN PROVIDER:		Telephone# _____
PHARMACY:		Telephone# _____
MEDICAL SUPPLY:		Telephone# _____
DOCTOR'S HOSPITAL:		Telephone# _____
DIALYSIS CENTER:		Telephone# _____
ATTENDANT'S NAME:		Telephone# _____
NEXT OF KIN:		Telephone# _____
Name and Relationship		

DO YOU USE ANY SPECIAL EQUIPMENT?

(Please check **ALL** that apply)

- 1 ___ I DO NOT USE ANY SPECIAL EQUIPMENT
 - 2 ___ I USE SUCTION EQUIPMENT
 - 3 ___ I USE A FEEDING PUMP
 - 4 ___ I USE A NEBULIZER
 - 5 ___ I USE A CONCENTRATOR
 - 6 ___ I REQUIRE OXYGEN
 HRS/DAY _____ LITRE FLOW _____
 - 7 ___ I USE A VENTILATOR
 - 8 ___ I USE IV EQUIPMENT
 - 9 ___ I AM ELECTRIC DEPENDENT
- PLEASE TELL US WHY?

WHAT IS YOUR DISABILITY?

(Please check **ALL** that apply)

- 1 ___ I HAVE NO DISABILITIES
- 2 ___ I AM BLIND
- 3 ___ I AM HEARING IMPAIRED
- 4 ___ I AM IN A WHEELCHAIR
- 5 ___ I AM BEDRIDDEN
- 6 ___ OTHER:

"I SUFFER FROM THE FOLLOWING CONDITIONS...." (Please check ALL that apply)

- | | | |
|----------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> HEART PROBLEMS (HP) | <input type="checkbox"/> CONTAGIOUS DISEASES (CD) | <input type="checkbox"/> DEPRESSION (DP) |
| <input type="checkbox"/> BLOOD PRESSURE (BP) | <input type="checkbox"/> CENTRAL VENOUS LINE (CL) | <input type="checkbox"/> ADHD/OCD (BH) |
| <input type="checkbox"/> STROKE (ST) | <input type="checkbox"/> DNR ORDERS (DN) | <input type="checkbox"/> IMMUNE SUPPRESSED (IS) |
| <input type="checkbox"/> DIABETES (DB) | <input type="checkbox"/> TRACHEOSTOMY (TR) | <input type="checkbox"/> CANCER (CA) |
| <input type="checkbox"/> BREATHING PROBLEMS (BR) | <input type="checkbox"/> INCONTINENCE (IN) | TYPE: _____ |
| <input type="checkbox"/> BACK PROBLEMS (BK) | <input type="checkbox"/> ALZHMERS (AZ) | <input type="checkbox"/> DIALYSIS (DI) |
| <input type="checkbox"/> SEIZURES/CONVULSIONS (SC) | <input type="checkbox"/> AUTISM (AU) | # WEEKLY _____ |
| <input type="checkbox"/> OTHER CONDITION _____ | | |

"I TAKE THESE TYPES OF MEDICATIONS...." (Please check ALL that apply)

- SELF ADMINISTERED AND SHELF KEPT
- INTRAVENOUS, SELF ADMINISTERED, AND SHELF KEPT
- INTRAVENOUS, SELF ADMINISTERED, AND REFRIGERATION IS REQUIRED
- NON-SELF ADMINISTERED MEDICATIONS
- I DO NOT TAKE ANY MEDICATIONS

PLEASE LIST ALL PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS YOU TAKE --DOSAGES & FREQUENCY:

You may attached a separate sheet to this application if the space provide is not sufficient.

PLEASE TELL US ABOUT YOUR TRANSPORTATION (Please check ONE)

- I WILL PROVIDE MY OWN TRANSPORATION TO A SHELTER
- I NORMALLY RIDE THE BUS
- I AM CONFINED TO A WHEELCHAIR
- I AM TOTALLY BEDRIDDEN
- I HAVE A HEARING/SEEING EYE ANIMAL ACCOMPANYING ME

ACKNOWLEDGEMENT

The information contained herein is true and correct to the best of my knowledge. I have read the Special Needs Assistance Population Program Applicant Information sheet accompanying this request and I understand the limitations on the services and level of care available. I understand that this registration is voluntary and hereby request registration in the Pasco County Special Needs Assistance Population Program.

I understand, based on the information I have provided, that I may or may not be assigned to a special needs unit based on the criteria stated in the information provided. I understand that I am responsible for providing any prescription medications, oxygen supplies, medical equipment, and special dietary items that I may require during the emergency. If my physician determines that I need a higher level of care than can be provided in a Special Needs Unit and makes arrangements by pre-admitting me to a medical facility, 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 understand that assistance will be provided only for the duration of the emergency, and that alternative arrangements should be made in advance in case I am not able to return to my home. 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 hereby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue.

SIGNATURE: _____

DATE: _____

REPRESENTATIVE (If you are unable to sign): _____

RELATIONSHIP TO THE APPLICANT: _____

*******FOR OFFICE OF EMERGENCY MANAGEMENT USE ONLY*******

SECTION	TSHP	RANGE	LEVEL	SHELTER	SNU	T	COFL	AMB	NOTES