

# MANATEE COUNTY EMERGENCY MANAGEMENT

## SPECIAL NEEDS PROGRAM QUESTIONNAIRE

Emergency Management is mandated by Florida Statutes to maintain a voluntary registry of persons who will need assistance during emergency evacuations. Records relating to registration of disabled citizens are exempt from the Provisions of F.S. 119.07(1), Public Records Law

Please complete this form to register for the Special Needs Program and return to: **DO NOT FAX**  
**Manatee County Emergency Management, P.O. Box 1000, Bradenton, FL 34206-1000** Phone: 941-748-4501 x 3500

### Transportation Registration

**Last Name:** \_\_\_\_\_ **First :** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Nick Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_ yrs. **SSN:** \_\_\_\_ -- \_\_\_\_ **Height** \_\_\_\_ ft. \_\_\_\_ in. **Weight:** \_\_\_\_ lbs.

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

1.  Private Home  Manufactured Housing  Apartment/Condo  
 HUD Housing  Assisted Living Facility  Independent Living Facility/Group Home  Nursing Home  
 Hotel  Other \_\_\_\_\_

Complex Name: \_\_\_\_\_

2.  Own  Rent **3. Primary Language**  English  Spanish  Other \_\_\_\_\_

4. Live Alone  Yes  No If No, with whom do you live?: \_\_\_\_\_

5. Do you have access to a generator?  Yes  No Do you have access to generator fuel?  Yes  No

Do you know how to safely operate and refuel the generator?  Yes  No

TRANSPORTATION WILL ONLY BE PROVIDED TO A GENERAL POPULATION SHELTER, A SPECIAL NEEDS SHELTER OR A HOSPITAL/NURSING HOME. PLEASE BE AWARE THAT IF YOU CHOOSE AN AMBULANCE AS YOUR TRANSPORTATION SOURCE, YOU WILL BE TRANSPORTED **ONLY** TO A HOSPITAL OR NURSING HOME.

**Own Transportation** \_\_\_\_\_ **Bus/Handi-Bus** \_\_\_\_\_ **Ambulance is Required** \_\_\_\_\_

### Special Needs Shelter Application

- 1) **ONLY DOGS AND CATS ARE ALLOWED AT THE SpNS..... PRIOR ARRANGEMENTS SHOULD BE MADE.**  
2) **SPECIAL DIETS ARE NOT PROVIDED. ....BRING YOUR OWN SPECIAL DIET FOOD**  
3) **LIMITED NUMBERS OF ARMY COTS ARE AVAILABLE. COT WEIGHT LIMIT 250 LBS. BRING YOUR OWN COT TO ASSURE THAT YOU HAVE ONE. YOU MUST BE ABLE TO GET UP AND DOWN FROM A COT**

**Total Number of Family Members Sheltering with You** \_\_\_\_\_ **You Need to Bring a Care Giver With You.**

**Caregiver's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Are you confined to a bed  YES  NO Use a Wheel Chair  YES  NO

Use a Cane or Walker  YES  NO **On electrical life support**  YES  NO

C-PAP  YES  NO Apnea Monitor  YES  NO

Require Oxygen Liters/Min. \_\_\_\_\_  YES  NO Have an Oxygen Regulator  YES  NO

Have an Oxygen Concentrator  YES  NO Have a portable Oxygen Tank  YES  NO

On a Respirator  YES  NO On a Ventilator  YES  NO

#### Oxygen concentrators must be brought to the Special Needs Shelter!!! Assistance Will be Provided.

Require a Nebulizer  YES  NO Receiving I.V. Infusion  YES  NO

Require Dialysis ? \_\_\_\_\_ x per Wk.  YES  NO Have/Require Dressing Changes  YES  NO

Dialysis Type  Peritoneal  Hemodialysis NG tubes/ colostomy  YES  NO

Immune Suppression  YES  NO Central Venous Line  YES  NO

Indwelling Catheter  YES  NO Tube Feeding  YES  NO

Have a Tracheostomy  YES  NO Suction Equipment  YES  NO

Incontinent  YES  NO Medication Requiring Refrigeration  YES  NO

Do Not Resuscitate (DNR) Status  YES  NO DNR Attached  YES  NO

Alzheimer's disease  YES  NO Dementia  YES  NO

Attention deficit hyper. disorder  YES  NO Obsessive compulsive disorder  YES  NO

Autism  YES  NO Conduct disorder  YES  NO

Anxiety  YES  NO Depression  YES  NO

Legally Blind  Deaf  Mute **Assistive Device**  YES  NO

Do you have a **service** animal?  YES  NO If yes, Type of animal: \_\_\_\_\_ Type Service: \_\_\_\_\_

I authorize emergency response personnel to enter my home for search and rescue operations  YES  NO

**Signature of the Person Requesting Assistance and/or Sheltering** \_\_\_\_\_

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

**DISCHARGE PLANNING INFORMATION**

In the event that your home is damaged and you are not able to return home, this information will be used to assist the Department of Elder Affairs in finding a place for you to stay.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ yrs. Social Security Number: \_\_\_\_ -- \_\_\_\_ .

**Insurance Information and ID Number(s)**

<input type="checkbox"/> Medicare:	<input type="checkbox"/> Medicaid:
<input type="checkbox"/> Champus:	<input type="checkbox"/> Private Insurance:
<input type="checkbox"/> TriCare for Life:	<input type="checkbox"/> Other:

Veteran  Yes  No

1. If someone calls to inquire if you are in this shelter, do we have permission to tell them you are here?  Yes  No

2. Do we have permission to tell them where you have relocated once you leave the shelter?  Yes  No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**POST EVENT PLANNING**

1. If you can't return home when the shelter closes, do you have an alternative plan for housing?  Yes  No

2. If yes, where will you go? \_\_\_\_\_

Contact information for relocation site: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

3. Do you have transportation?  Yes  No If yes, describe: \_\_\_\_\_

4. Do you receive services from a Physician or Outside Agency?  YES  NO

If Yes, Primary Physician:  Yes  No Physician Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If Yes, Hospice:  Yes  No Agency Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If yes, Home Health:  Yes  No Agency Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If yes, Nurse Registry:  Yes  No Agency Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If yes, Oxygen Provider:  Yes  No Agency Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If yes, Medical Equipment Provider:  Yes  No Agency Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If yes, Dialysis Provider:  Yes  No Agency Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If Yes, Pharmacy:  Yes  No Pharmacy Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

5. Local Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_

6. Non-Local Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_

7. Do you have a pet?  YES  NO Type & Number  Dog(s) # \_\_\_\_\_  Cat(s) # \_\_\_\_\_

Other Type \_\_\_\_\_

Veterinarian Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_

8. E-mail Address:  YES  NO If Yes: \_\_\_\_\_

\_\_\_\_\_

