MEDICAL SPECIAL NEEDS SHELTER

Part of the Special Needs Program of Manatee County

Please read and keep all the information about the medical special needs shelter before filling out this application. Filling out this application does not guarantee access to the medical special needs shelter.

Return this form to Manatee County Emergency Management, PO Box 1000, Bradenton, Florida 34206

INFORMATION FOR THE PERSON NEEDING HELP

First Name _____ MI _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____/_____/_____ ☐ Male ☐ Female

Height _____ Weight _____

Physical Address (include apartment/lot #) _____

Subdivision _____ City _____ Zip Code _____

Primary Phone _____ Secondary Phone or TTY/TDD _____

Residence Type [check one box]:

☐ Single Family Home ☐ Multi-Family Home ☐ Apartment ☐ Mobile Home

Mailing Address: (Please enter **ONLY** if different than your Physical Address)

Mailing Address _____ City _____ Zip Code _____

CAREGIVER INFORMATION: YOU MUST BRING A FULL-TIME CAREGIVER TO THE SHELTER

First Name _____ MI _____ Last Name _____

Address (include apartment/lot #) _____

City _____ FLORIDA Zip Code _____

Primary Phone _____ Secondary Phone or TTY/TDD _____

OTHER CONTACT INFORMATION

EMERGENCY CONTACT NAME _____

Address: _____

City: _____ Zip Code: _____

Relationship: _____

Primary Phone: _____

☐ Checking this box allows medical information to be shared with this Emergency Contact

ADDITIONAL CONTACT INFORMATION

Physician Name _____ Phone Number _____

Home Health Provider _____ Phone Number _____

Pharmacy Name _____ Phone Number _____

EVACUATION ASSISTANCE INFORMATION

DO YOU NEED TRANSPORTATION ASSISTANCE TO THE MEDICAL SPECIAL NEEDS SHELTER

- ☐ Yes, I need transportation assistance (bus or handy bus).
- ☐ No, I do not need transportation assistance. I have my own transportation.

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

- ☐ Blind/Low Vision
- ☐ Deaf/Hard of Hearing
- ☐ Speech Impediment
- ☐ Physical Disability (Please Explain)
- ☐ Bedridden
- ☐ Unable to get up/down from a cot
- ☐ Mentally / memory impaired
- ☐ Dementia/Alzheimer's
- ☐ Anxiety or Obsessive Compulsive Disorder (OCD)
- ☐ Depression
- ☐ Dialysis
- ☐ Requires constant skilled nursing care (e.g., open wounds or dressing changes
- ☐ I.V.s
- ☐ Central Venous Line
- ☐ Assistance with medications
- ☐ Assistance needed with insulin
- ☐ Requires refrigerated medications
- ☐ Autism
- ☐ Suction Machine
- ☐ Catheters
- ☐ Colostomy
- ☐ Feeding Tube
- ☐ Do Not Resuscitate (DNR)
- ☐ Hospice
- ☐ Needs help walking
- ☐ Use a walker or cane
- ☐ Uses a standard wheelchair
- ☐ Motorized wheelchair
- ☐ Motorized Scooter
- ☐ Oxygen Dependent: Check all that apply and supply detailed information (O2 Type, Liters Flow, O2 Company and contact information)
  - ☐ 24-Hour
  - ☐ Only overnight
  - ☐ Nebulizer
  - ☐ CPAP
  - ☐ Ventilator
  - ☐ Other, please list

  _____

DO YOU HAVE A SERVICE ANIMAL?

☐ YES: Type of Animal _____ Type of service provided _____

☐ NO

ADDITIONAL COMMENTS / INFORMATION:

How many people will be sheltering with you? _____

Are you able to get on a bus using the steps? ☐ YES ☐ NO

Are you able to get on a bus using the lift? ☐ YES ☐ NO

Please include any additional information that may be helpful

☐ I authorize emergency response personnel to enter my home for search and rescue operations.

_____ _____

SIGNATURE OF INDIVIDUAL REQUESTING ASSISTANCE (OR LEGAL GUARDIAN) DATE

NAME OF PERSON FILLING OUT THIS FORM (if not the individual) _____ PHONE _____