



APPLICATION TO REGISTER FOR THE SPECIAL NEEDS PROGRAM

The Patient is responsible for completing, signing and returning this **two-page** form to:
Lee County Emergency Management, Attention Debbie Quimby, P.O. Box 398, Fort Myers, FL 33902-0398
FOR INFORMATION CALL (239) 477-3640 / FAX # (239) 477-3636

Registration officially turns off when Lee County enters into the 5-day forecast cone.

SPECIAL NEEDS APPLICANT – Please complete the following shelter registration (PLEASE PRINT):

Last Name: _____ First: _____ Date of Birth: _____

Address: _____ Street: _____ City: _____ Zip: _____

Mailing Address: _____ Subdivision Name: _____

Home Phone: _(____)_____ Cell/Alternate Phone: _(____)_____

Caregiver's Name: _____ Phone: _____

Emergency contact, other than your Caregiver: _____

Relationship: _____ Phone Number: _____

Print Physician's Name: _____ Phone Number: _____

Veterans: Are you registered at the Fort Myers VA Clinic? Yes or No

Do you live in a Manufactured, Mobile Home/Trailer? Yes or No

Recommended Level of Care – check all that apply

The physician in charge of the Dept. of Health will review and assign to the appropriate shelter based on stated criteria.

Special Care Shelter for the Following Conditions:

- | | |
|--|--|
| <input type="checkbox"/> Walks less than 100 feet without assistive device | <input type="checkbox"/> Terminally ill (Hospice shelter as first preference) |
| <input type="checkbox"/> Wheelchair bound | <input type="checkbox"/> Requires constant, reliable source of electricity |
| <input type="checkbox"/> Oxygen dependent | <input type="checkbox"/> Chronic wounds/ulcers requiring dressing changes |
| <input type="checkbox"/> Ostomy, foley or external catheter, self-catheter (circle) | <input type="checkbox"/> Medical equipment required at least 4 times daily (ex: IV pump, nebulizer) Specify: _____ |
| <input type="checkbox"/> Recent hospital discharge (physician/patient judgment) | <input type="checkbox"/> Requires assistance or supervision with medications, IM or IV injections |
| <input type="checkbox"/> Transfers with assistance (but weighs less than 300 lbs) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Home peritoneal dialysis | |
| <input type="checkbox"/> Unable to make independent judgments for own welfare (Alzheimer's, dementia, etc.) Specify: _____ | |

Transportation to Shelter

- I will provide my own transportation
- I will walk to bus pickup point
- I am ambulatory with assistive device
- I require a wheelchair lift vehicle
- I am bedridden and require stretcher

Emergency Public Shelter

- I need transportation to public shelter
- Visually impaired Hearing impaired
- Ambulatory Bowel/bladder continent
- Mentally competent Stable hemodialysis
- Can manage own daily medications

You must have a Caregiver if assigned to either a Special Care Shelter or a Hospital.

*****CONTINUE TO PAGE 2 OF APPLICATION*****

Revised 2/07

| Hospital Care for the Following Conditions: | |
|---|---|
| <input type="checkbox"/> Bedridden <input type="checkbox"/> Weighs more than 300 lbs and requires personnel or mechanical asst with transfers <input type="checkbox"/> Ventilator dependent-respiratory status: _____ <input type="checkbox"/> Combative, prone to wander, violent tendencies <input type="checkbox"/> Medical equipment required continuously (specify): _____ | <p><u>NOTE TO DOCTOR:</u> A copy of your letter/script (separate from this form) must be dated current year & included with this application stating patient must be evacuated to a hospital in event of hurricane. Patient takes original with him/her if evacuated.</p> <p>Suggested/Preferred Hospital: _____</p> <p>Doctor's Signature: _____</p> |

| Mobility/Special Equipment | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Walker/Cane | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Service animal | <input type="checkbox"/> Feeding tube, blender, liquid food |
| <input type="checkbox"/> Amputee (limb) | <input type="checkbox"/> Paraplegic | <input type="checkbox"/> Quadriplegic | <input type="checkbox"/> Nebulizer (breathing machine) |

Allergies: Yes or No (If yes, please explain) _____

Pets: Yes or No (**Service animals only** are permitted at Special Care Shelters, no others are allowed.)

MEDICATION NOTE: If evacuated, it is important that you bring with you at least a two-week (preferably a one-month) supply of all your medications in their original containers!

Records relating to the registration of special needs citizens are exempt from the provision of S.119.07(1), Florida Statutes.

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet accompanying this request and I understand that there are limitations on the services and levels of care that are available.

I understand that the Special Care Shelter will be open only for the duration of the emergency. I need to make plans in advance for alternate living arrangements in case my home is destroyed or if I am not able to return to my home for an extended period of time.

I understand that I may or may not be assigned to a Special Care Shelter based on the information I have provided, available space at those facilities, and the criteria to be met for the shelter residents.

I also understand that I will be responsible for any charges and costs associated with hospital, medical facility care and/or medical transportation.

I hereby grant permission to medical providers, transportation agencies and others, to provide care and respond to my needs, and for the disclosure of any information necessary to do so. I also grant permission to emergency response agencies to enter my residence for the purpose of emergency search and rescue, and authorize the release of information necessary for these agencies to perform these services.

In an effort to ensure the safety of all shelter residents, a background screen will be run on all people evacuating to the Special Care Shelter, including the caretakers. I understand this registration is voluntary and do hereby request to be registered in the Lee County Special Needs Program.

Patient Signature: _____

Date: _____

Print Patient Name: _____

Witness signature: _____

Date: _____

(If unable to sign, please have your Representative sign above)