

**Indian River County  
Special Needs Program Application**

Updated 01-2011

Date:

Complete one application per person. Please print clearly. You may be contacted by a member of the Emergency Services staff to review your application and answer any questions you may have.

**APPLICANT INFORMATION**

SS#	First Name:	Middle Initial:	Last Name:
Date of Birth: (Month-Day-Year)		Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address: (Include Lot or Apt. #)		City:	
State: FL	Zip Code:	Phone:	E-Mail Address:

**RESIDENCE**

Private Home     Apartment     Condo     **Manufactured/Mobile Home**

Name of Complex, Subdivision, or Development:

Are you a full time resident of Indian River County?    Yes     No

**MAILING ADDRESS (If different from address above)**

Street Address:	City:	State:	Zip Code:
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**EMERGENCY CONTACT INFORMATION**

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

**EVACUATION INFORMATION**

**TRANSPORTATION – Do you need transportation to a shelter? (please select one):**  
 1.     **Yes**, I need transportation.     **No**, I will transport myself.

2.    **If you answered yes above, what kind of vehicle do you require? (please select one):**  
 Regular vehicle     Wheelchair vehicle     Stretcher vehicle

If assistance is needed, each applicant is requested to be accompanied by one caregiver. Name of caregiver: \_\_\_\_\_ Phone: \_\_\_\_\_

**ARE YOU A PET OWNER? Yes  No**  The Humane Society has a program to care for your pet while you are at the Special Needs Shelter. If you are interested in this program, please select "Yes" in the box provided and someone will contact you to make the necessary arrangements.

**MEDICAL INFORMATION**

Are you a Hospice patient?     Yes     No

Name of home health care agency, if applicable:	Phone:
Name of Pharmacy:	Phone:
Name of Primary Physician:	Phone:
Name of oxygen provider, if applicable:	Phone:



**SPECIAL NOTES**

As a special needs shelter evacuee, I am entitled to pre-authorize emergency response personnel to enter my home during search and rescue operations, if necessary, to assure my safety and welfare following a disaster as defined in Florida Statutes 252.34.

Yes, I do pre-authorize.  No, I will not pre-authorize.

I understand that the Special Needs Shelter will not be air conditioned if emergency power is required.

I understand that I need to bring with me all medications, in marked bottles, and all medical supplies I use for my care for up to 14-days (two weeks).

I understand that I must bring my own bedding. The Special Needs Shelter will not supply cots or other bedding.

Part of my emergency plan includes designating alternate living arrangements (home of friend or relative, etc.) in the event my home is severely damaged and I am unable to return.

***My alternate plan is to temporarily reside at the following location:***

I understand that once this public shelter has been closed following the emergency event, it will be my responsibility to either return home or seek other living arrangements.

**\*\*\*READ AND SIGN\*\*\*READ AND SIGN\*\*\*READ AND SIGN\*\*\*READ AND SIGN\*\*\***

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Department of Emergency Services will determine which emergency evacuation assistance, if any, this program may be able to provide. Further, I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

**Signature:**

**Date:**

**APPLICANT REPRESENTATIVE**

If the person completing this form is not the applicant, please answer the following:

Name: \_\_\_\_\_ Relationship/Agency: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone: \_\_\_\_\_ Applicant has been notified of this registration: Yes  No

**OFFICIAL USE ONLY**

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Category: \_\_\_\_\_ Sector #: \_\_\_\_\_  
Applicant Contacted: \_\_\_\_\_ Pre-Registered:  Yes  No Type of Stay:  Patient  Caregiver  
Type of Shelter:  Regular  SNS  Hospital  Hospice  Patient/Caregiver

**\*\*\*Return Application to\*\*\***

IRC Dept. of Emergency Services (ATTN: SNS)  
4225 43<sup>rd</sup> Avenue  
Vero Beach, FL 32967