

**Indian River County
Special Needs Program Application**

Form 01-2010

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: Vero Beach <input type="checkbox"/> Sebastian <input type="checkbox"/> Fellsmere <input type="checkbox"/>	
State:	Zip Code:	Phone: () -	

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: () -

ALLERGIES

Allergies: Are you allergic or sensitive to any medication(s)? Yes No

If yes, please explain which medications and what the reaction was:

Mobility:

- I can walk **with** help
- I walk **without** help
- I use a walker
- I use a cane
- I use a wheelchair/scooter
- I am bedridden

Respiratory Support:

- I use oxygen support and understand that I must bring an ample supply to get me to and from home. _____ Hours per day
_____ Liter flow
- I use a Nebulizer _____ Times per day

General Medical Conditions:

- | | |
|--|--|
| <input type="checkbox"/> I use Insulin for <i>DIABETES</i> | <input type="checkbox"/> Severe arthritis |
| <input type="checkbox"/> I use Oral Medication for <i>DIABETES</i> | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Paralysis <input type="checkbox"/> Complete <input type="checkbox"/> Partial | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Dialysis <input type="checkbox"/> Home Dialysis <input type="checkbox"/> Dialysis Center | <input type="checkbox"/> Deaf /hearing impaired |
| Number of times dialyzed per week: _____ | <input type="checkbox"/> Blind (guide dog <input type="checkbox"/>) |
| Name of dialysis center: _____ | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Open wounds that require dressing changes. How often? _____ | <input type="checkbox"/> Ostomy |
| <input type="checkbox"/> Pregnant? Due date: _____ | <input type="checkbox"/> Memory impairment |
| <input type="checkbox"/> Medications that require refrigeration? _____ | <input type="checkbox"/> Electric Dependent |
| | <input type="checkbox"/> Other: _____ |

Medications (Attach a separate sheet if necessary)

Prescription Medications

Over-the-counter (OTC) medications

Rx Name	Dose	How Often	OTC Name	Dose	How Often

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

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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Stay: <input type="checkbox"/> Patient <input type="checkbox"/> Caregiver	
Type of Shelter: <input type="checkbox"/> Regular <input type="checkbox"/> SNS <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice	<input type="checkbox"/> Patient/Caregiver		

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

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

Questions? Call (772) 567-2154

On-Line form: www.irces.com