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:

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

Transportation to Shelter	Emergency Public Shelter	
☐ I will provide my own transportation	☐ I need transportation to public shelter	
☐ I will walk to bus pickup point	☐ Visually impaired	☐ Hearing impaired
☐ I am ambulatory with assistive device	☐ Ambulatory	☐ Bowel/bladder continent
☐ I require a wheelchair lift vehicle	☐ Mentally competent	☐ Stable hemodialysis
☐ I am bedridden and require stretcher	☐ 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:	
☐ Bedridden ☐ Weighs more than 300 lbs and requires personnel or mechanical asst with transfers ☐ Ventilator dependent-respiratory status: ___________ ☐ Combative, prone to wander, violent tendencies ☐ Medical equipment required continuously (specify): _______________________	**NOTE TO DOCTOR**: 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. Suggested/Preferred Hospital:__________________ Doctor's Signature: ___________________________

Mobility/Special Equipment			
☐ Walker/Cane	☐ Wheelchair	☐ Service animal	☐ Feeding tube, blender, liquid food
☐ Amputee (limb)	☐ Paraplegic	☐ Quadriplegic	☐ 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 Statues.

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)