

Special Needs Shelter (SpNS) and Evacuation Assistance Application

Recommended Use

Development History:

The Special Needs Shelter, Interagency Committee, Registry Subcommittee developed this form based on the identified issues as suggested during the November 2007 meeting to provide the basic information as required per 64-3.050 F.A.C. for standardization and consistency of information being collected through the registry format. No objections were noted on the use or sharing of this form when presented to the Interagency Committee during the May 8th, 2008 meeting in Tallahassee. Sub-committee members include representation from Department of Health including Children's Medical Services, Department of Emergency Management, Department of Elder Affairs, Agency for Persons with Disabilities, Home Health, Alzheimer's or Cognitive Impairment partners, private and other interested partners. Posted membership invitations for this and other Sub-committees may be found on the SpNS Web Board.

Purpose and Use:

Developed for the voluntary use of the SpNS Registry designee responsible to collect registry information. All information as provided is required to be obtained for registry applicants however, **the use of this form is not mandatory or required**. Many registry forms have been updated effective November 2007 and meet the requirements. Others may find this tool useful in efforts to meet the requirements. The application information as provided within this template should not be removed but may be expanded based on user needs to include more detailed information in specific areas and/or personalized information.

Key Considerations:

- Use of this form is not mandatory or required
- All information provided is required per 64-3.050 F.A.C.
- Clarifying statements may be added to the form, (i.e., information to reflect the approval process, including when the applicant or designee will be contacted regarding the status of the application and/or transportation request).
- Changes to the form may reflect personalization (i.e., county name, contact information) and any other additional or expanded information as needed.
- SpNS/Transportation partners should be part of the adoption of new or revised forms when applicable and have knowledge of adopted forms as determined by the SpNS Registry designee responsible to collect registry information.
- Information may be added to the Registry Application that is similar to any SpNS Intake forms being used by that county (i.e. information on or need for a caregiver).

Disclaimers:

The IAC and Registry Subcommittee does not endorse or support any removal or additions of information which will vary from the form provided. The IAC and Sub-committees will not review and/or approve changes to the form.

Special Needs Shelter (SpNS) and Evacuation Assistance Application

NAME Last: _____ First: _____ Middle: _____

Residence Type: Mobile/manufactured Single Family Apartment/Condo Other: _____

Street Address: _____

Apartment #: _____ Building # _____ Name of Complex or Sub-Division _____

City: _____ State: _____ ZIP: _____ County of residence: _____

Mailing address if different than above: _____

Phone #: _____ Alternate Phone # _____

DOB: _____ Age: _____ (years) Sex: Male Female Weight: _____ (lbs) Height: _____ (ft.) _____ (inches)

Primary Language: _____

Living Situation: Alone Relative Care giver Other _____

Emergency Contacts: Local: _____ Relationship: _____ Phone: _____
 Non - Local: _____ Relationship: _____ Phone: _____

Transportation (Evacuation Assistance)

I require transportation: Yes No

Transportation Needs: Car Bus Wheelchair Van Ambulance
 Other: _____ Number of Persons to Transport: _____

If the application is to request transportation/evacuation assistance only, you are not required to complete the following information

Special Medical Needs of Applicant

Will you be accompanied to the Special Need Shelter? Yes No

If yes, number of care givers/ family members accompanying Individual to the SpNS: _____

<p>Medically Dependent On Electricity:</p> <p><input type="checkbox"/> O2 Concentrator <input type="checkbox"/> Feeding Pump</p> <p><input type="checkbox"/> Suction</p> <p><input type="checkbox"/> Other: _____</p> <p>_____</p>		<p>Oxygen Dependent:</p> <p><input type="checkbox"/> 24 hour <input type="checkbox"/> Only Overnight <input type="checkbox"/> Intermittent</p> <p>Oxygen Type: _____</p> <p>Mode of administration</p> <p><input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Mask</p> <p>Liters flow: _____ L /minute</p>	
<p><input type="checkbox"/> Assistance with medications</p> <p><input type="checkbox"/> Medication requiring refrigeration</p> <p><input type="checkbox"/> Insulin Dependent</p> <p><input type="checkbox"/> Assistance needed with wound care. Specify: _____</p>	<p><input type="checkbox"/> Mental Health Problems: _____</p> <p><input type="checkbox"/> Cognitive Impaired: _____ (i.e., Alzheimer's, dementia)</p> <p><input type="checkbox"/> Has behavioral challenges: Specify: _____</p>	<p>List any assistive devices such as glasses, white cane, hearing aid.</p> <p><input type="checkbox"/> Vision Loss/ Impaired _____</p> <p><input type="checkbox"/> Hearing Loss/Impaired _____</p> <p><input type="checkbox"/> ASL</p> <p><input type="checkbox"/> Speech Impaired _____</p>	

