HENDRY COUNTY
SPECIAL NEEDS SHELTER REGISTRATION REQUEST FORM

Submit Forms To: Hendry County Emergency Management, Special Needs Shelter,

PO Box 2340, LaBelle, FL 33975

*****FORMS NEED TO BE SUBMITTED ANNUALLY*****

NAME: (Please Print)_____ DATE Of BIRTH: _____

STREET ADDRESS: _____APT/LOT #_____

CITY: _____ ZIP: _____ DAY PHONE: _____ NIGHT PHONE:_____

RESIDENCE TYPE: □ House/Duplex □ Mobile Home □ Apartment/Condo Other – Specify_____

Subdivision/Complex/Park Name: _____ Office Phone Number: _____

□ MALE □ FEMALE HEIGHT: ____ft. _____in. WEIGHT: _____ lbs. AGE: _____

PRIMARY LANGUAGE: □ English □ Spanish □ Other – Specify _____

CAREGIVER - THE FOLLOWING PERSON **WILL BE ASSISTING ME IN THE SHELTER**:

NAME: _____ RELATIONSHIP: _____

CAREGIVER'S PHONE NUMBER(s) - DAY PHONE_____NIGHT PHONE: _____

PHYSICIAN/PROVIDERS

PRIMARY DOCTOR (Full Name) PHONE NUMBER

_____ _____

HOME HEALTH/HOSPICE AGENCY (Full Name/No Abbreviations) PHONE NUMBER

_____ _____

OXYGEN PROVIDER (Full Name/No Abbreviations) PHONE NUMBER

_____ _____

OTHER MEDICAL SUPPORT PROVIDERS	**PHONE NUMBER(S)**
PHARMACY: _____	_____
HOME MEDICAL EQUIPMENT: _____	_____
DIALYSIS: _____	_____

HOME CARE INFORMATION

□ I take care of myself at home □ I need part time nursing help at home

□ I am unable to care for myself at home □ I have full time nursing help at home

TRANSPORTATION REQUIREMENTS

□ I (we) have our own transportation and will drive to the shelter
□ I (we) request transportation
□ I (we) request transportation via wheelchair lift
□ I (we) request transportation via stretcher

If you are requesting transportation, please answer the following questions:
If using a wheelchair, can you transfer to a van seat? □ Yes □ No
If a stretcher is needed, please explain why _____
_____
List equipment your life depends on that must be transported with you (such as oxygen concentrators):
_____
How many people going to the shelter: _____ Number to be picked up: _____

***Food and water will not be provided. Special needed dietary items must be brought. Items need to be non-perishable and last for up to 72 hours. There will be no access to a refrigerator, stove or a microwave.**

SPECIAL/MEDICAL NEEDS – Please mark all that apply

- ☐ Wound care daily or more often
  Type of wound: _____
- ☐ Ostomy care assistance
- ☐ Catheter care assistance
- ☐ Suction equipment
- ☐ Feeding Pump
- ☐ RN to assist with medicines or daily injections
- ☐ Requires assistance with insulin and checking blood sugar
- ☐ RN to assist with IV's - ***Include copy of Prescription or written instructions***
- ☐ Ventilator dependent (stable)
- ☐ Medicines that require refrigeration
- ☐ Medical electrical equipment required to maintain health status:
  ___ CPAP ___ Nebulizer ___
  Other _____
- ☐ Oxygen dependent:
  ___ 24 hr. ___ Nighttime ___ PRN
  ___ High flow ___ Low flow Liters per minute_____
- ☐ Arthritis/osteoporosis
- ☐ Cardiac device - if checked, please specify: _____

OTHER NEEDS - Please mark all that apply

- ☐ Vision Impariment - please check: ____ Use of glasses/corrective lenses ____ Blind
  If blind, please check: ____ Left Eye _____ Right Eye _____ Both Eyes
- ☐ Hearing Impaired - If use of Hearing aide(s), please check:____ Right Ear ____Left Ear _____ Both Ears
- ☐ Use of Cane/Walker*
- ☐ Use of Wheel chair*
- ☐ Use of Electric wheel chair*
- ☐ Trained service animal - if checked, please specify: _____
- ☐ Special dietary needs - If checked, please specify: _____

***Make sure that your name is on the item**

MEDICAL AND ADDITIONAL INFORMATION – Please mark all that apply

- ☐ Seizures
- ☐ Diabetes
- ☐ Cardiac - If checked, please specify:
  ___ Congestive Heart Failure ___ Angina ___ High Blood Pressure ___ Stroke
- ☐ Quadriplegic or Paraplegic – If checked, please specify: _____
- ☐ Alzheimer's – If checked, please specify: ___ Early ___ Moderate ___ Advanced
- ☐ Dialysis – If checked, please specify ___ Hemodialysis ___ Peritoneal
- ☐ Dementia and/or Confusion – If checked, please specify: _____
- ☐ Immune System Problems – If checked, please specify: _____
- ☐ Mental Illness – If checked, please specify: _____
- ☐ Bed bound
- ☐ Unable to transfer bed to chair
- ☐ Unable to hold urine until bathroom is reached
- ☐ Unable to hold bowel movements until bathroom is reached
- ☐ More confused at night
- ☐ Strikes out when confused
- ☐ Speech impaired - If checked, please specify: _____

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MEDICATIONS

Please list your medications, your dosage, full name of the doctor who prescribed the medication and the doctor's phone number. **Attach additional paper if necessary.**

NAME OF MEDICATION	DOSAGE	FIRST AND LAST NAME OF PRESCRIBING PHYSICIAN	PHYSICIAN'S PHONE NUMBER (include area code)

ALLERGIES

Please list any medication allergies you may have. **Attach additional paper if necessary.**

_____

_____

_____

_____

_____

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ALTERNATIVE ARRANGEMENTS

Should your home sustain damage and you are not able to immediately return home, please list what your plans are and who can be contacted that you can stay with. Please list their names and phone numbers (including cell numbers). Please list at least one "Non-Local" contact in the event that our area needs to be evacuated.

Sheltering plan after an event:

_____
_____
_____
_____
_____
_____
_____

Contact Person: _____ Phone Number(s): _____

Contact Person: _____ Phone Number(s): _____

Contact Person (Non-Local): _____ Phone Number(s): _____

SIGNATURE

I have read, understood, and received a copy of the "Important Notice and Statement of Understanding".

I grant permission to health care providers, transportation agencies, and others as necessary to provide care and to disclose any information that is necessary to respond to my needs.

I understand that this registration is voluntary and hereby request registration for the Special Needs Shelter.

_____ _____

Signature of Registrant or Guardian Date

FORM MUST HAVE A SIGNATURE

TO BE COMPLETED BY HENDRY COUNTY HEALTH DEPARTMENT STAFF

- ☐ Meets criteria for Special Needs Shelter
- ☐ Nursing Home/Assisted Living Facility
- ☐ Hospital
- ☐ General Shelter

Signature: _____ Date:_____

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IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING

***PLEASE KEEP THIS SHEET FOR FUTURE REFERENCE. DO NOT RETURN WITH THE SHELTER REGISTRATION REQUEST FORM. THANK YOU. ***

I understand that:

- Emergency shelters, including the Special Needs Shelter, are made available to provide me protection and should be considered a shelter of last resort (if no other options are available).
- Limited nursing and medical assistance in the Special Needs Shelter will be available to assist me and/or my caregiver.
- Due to the limitation of services and conditions in a shelter, the level of services will not equal what I receive at home; and conditions in the shelter may be stressful and/or inadequate for my needs.
- Clients and caregivers are responsible to provide for their own basic and special needs while in the shelter.
- Clients will be accommodated on simple cots. Bedding will not be provided. Air mattresses, hospital beds, lawn and lounge chairs cannot be allowed due to lack of space.
- One person should accompany the patient as a caregiver. Unfortunately, cots cannot be provided to caregivers because this would limit the shelter capacity for clients.
- Clients must bring medications, all medical supplies and medical equipment (including oxygen concentrators) with them to the shelter. Medications must be in their original containers.
- Food and water will not be provided. Special needed dietary items may be brought. Items need to be non-perishable and last for up to 72 hours. There will be no access to a refrigerator, stove or a microwave.
- Clients and caregivers should bring personal hygiene items and extra clothing for 72 hours. Keep in mind that minimum space is available. Make sure that your name is on all items brought to the shelter. Clients/caregivers are responsible for their own items.
- Clients will not be allowed to smoke in the shelter or on the shelter grounds.
- Pets are not permitted in the shelter and arrangements for their care, while in the shelter, should be arranged in advanced. Trained service animals are admitted to the shelter and a 72 hour supply of non-perishable food is to accompany the animal.
- Clients with living wills, a Power of Attorney, and Do Not Resuscitate (DNRO) forms should bring a copy.
- Transportation is coordinated through Hendry County Emergency Management. All attempts will be made to give advance notice by phone, of the date and time to expect to be picked up for transport to a shelter. If I decline transportation when the transporter arrives, I understand that I may not have another opportunity to request this service.
- I will be responsible for any charges and costs associated with hospitalization or other medical facility including care and medical transportation, if they should become needed.
- I will need to make alternative arrangements in the event that I am unable to return to my home after the storm.
- I grant permission to health care providers, transportation agencies, and others as necessary to provide care, and to disclose any information that is necessary to respond to my needs.
- I understand that this registration is voluntary.