



Print Form

Submit by Email

APPLICATION TO REGISTER FOR THE SPECIAL NEEDS PROGRAM

Lee County Emergency Management, Attention Debbie Quimby, P.O. Box 398, Fort Myers, FL 33902-0398

FOR INFORMATION CALL (239) 533-3640 / FAX # (239) 477-3636

Applications will NOT be processed when Lee County is in the 5-day forecast cone.

Special Needs Applicant – You must complete an application each year (please type or print):

Last Name [] First Name [] Date of Birth []

Primary Language [] Height [] ft. [] in. Weight [] lbs.

I live alone I live with spouse or relatives I live with caregiver(s) Other, explain below

[]

Address [] Street/Unit # [] City [] Zip []

Mailing Address [] Subdivision []

Home Phone [] Alt/Cell Phone []

I live in a manufactured, trailer or mobile home I am a Veteran

Companion/Caregiver Name [] Companion/Caregiver Phone []

Emergency Contact, other than Companion/Caregiver []

Relationship [] Emergency Phone []

Physician's Name [] Physician's Phone []

Shelter & Transportation Needs: (please check one box only)

Table with 2 columns: I need a ride to: and I have a ride to: containing radio button options for shelter types.

Type of Transportation Needed:

Personal Health Concerns

- I will walk to a bus pickup point
I can walk limited distances only
I am ambulatory with assistive device
I am wheelchair/scooter bound-need handicap bus
I am bedridden - require ambulance transport

- Visually impaired
Hearing impaired
Developmental/cognitive impairment
Bowel/bladder incontinent
Unstable hemodialysis
Need help managing own daily medications

You must have a Companion/Caregiver if assigned to either a Special Care Shelter or a Hospital.

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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:	
<input type="checkbox"/> Walks less than 100 feet without assistive device <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Oxygen dependent - # ltrs : _____ <input type="checkbox"/> Ostomy, foley or external catheter, self-catheter <input type="checkbox"/> Recent hospital discharge (physician/patient judgment) <input type="checkbox"/> Transfers with assistance (weighs less than 300 lbs) <input type="checkbox"/> Unable to make independent judgments for own welfare, i.e. Alzheimer's, dementia, etc.	<input type="checkbox"/> Terminally ill (Hospice shelter first preference) <input type="checkbox"/> Requires constant reliable source of electricity <input type="checkbox"/> Chronic wounds/ulcers require dressing changes <input type="checkbox"/> Medical equipment required at least 4 times daily, ex: IV pump, nebulizer (specify below) <input type="checkbox"/> Requires assistance or supervision with medications, IM or IV injections <input type="checkbox"/> Home peritoneal dialysis <input type="checkbox"/> Other: (give details below)

Hospital Care for the Following Conditions:	
<i>Your doctor must send us written authorization before you can be sheltered in a hospital</i>	
<input type="checkbox"/> Bedridden <input type="checkbox"/> Weighs more than 300 lbs and requires personnel or mechanical assistance with transfers <input type="checkbox"/> Ventilator dependent-respiratory status: (details below) <input type="checkbox"/> Combative, prone to wander, violent tendencies <input type="checkbox"/> Medical equipment required continuously other than oxygen (specify below)	<p>NOTE TO DOCTOR: A copy of your letter/script (separate from this form) must be dated current year & included with this application stating the reason patient must be evacuated to a hospital in event of hurricane. Patient takes original with him/her if evacuated. Suggested/Preferred Hospital: _____</p> <input type="checkbox"/> Doctor's script mailed or faxed in

Mobility/Special Equipment:	
<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter (electric) <input type="checkbox"/> CPAP/Bi-Pap <input type="checkbox"/> Amputee (limb) <input type="checkbox"/> Paraplegic <input type="checkbox"/> Quadriplegic <input type="checkbox"/> Service animal <input type="checkbox"/> Oxygen dependent <input type="checkbox"/> Nebulizer (breathing machine) <input type="checkbox"/> Feeding tube, blender, liquid food	

I have allergies (details below)

I have a pet (Service animals only are permitted at Special Care Shelters, no others are allowed.)

Additional medical information:

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 Statutes.

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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 companion/caretaker. I understand this registration is voluntary and do hereby request to be registered in the Lee County Special Needs Program.

My submission of this form indicates I have read and understand the above instructions, and I agree to abide by the policies set forth for the Special Needs Program and the Special Care Shelter.

Client Signature: _____ Date: _____

If you utilize the services of a HOME HEALTH PROVIDER, NURSE REGISTRY, or DURABLE MEDICAL EQUIPMENT PROVIDER, provide their contact information below.

Company /Provider: _____

Provider Contact Name: _____

Contact Phone No. _____