

2007 Special Needs Registry

Individuals are eligible to be registered with the Special Need Registry if they are frail, elderly, medically needy and/or disabled and are not served in or by a residential facility program. Eligible clients are required to complete and sign this application and the HIPAA Disclosure of Information and HIPAA Privacy Act forms before they are placed on the registry.

Social Security# _____ - _____ - _____ Medicaid # _____ Medicare# _____

Last Name _____ First _____ Middle Initial _____

Physical Address _____ Key _____

Mailing Address (if different) _____ City _____ Zip _____

Do you plan to evacuate to a public shelter? -----Y _____ N _____

Do you need Monroe County to transport you to a shelter? ----- Y _____ N _____

(If you answered *no* to both of the above, you will not be registered and need only to sign the back of the form. If you answered *yes* to either or both please continue to complete the form front and back.)

If you do not have a phone, you must list a neighbor's phone number that we may use to contact you.

Nearest Mile Marker _____ Home Phone# _____ Spanish only? Y _____ N _____

Sex M _____ F _____ Date of Birth _____

If married: Name of Spouse _____ Is Spouse registered? Y _____ N _____

Residence type (please check one): Single family home/Duplex _____ Apartment _____ Boat _____

Condo _____ Campground/RV _____ Mobile Home _____ Other _____

Number of Pets in home: Dog _____ Cat _____ Other (type & #) _____

NOTE: Pets of Special Needs Registry clients are eligible to, if pre-registered, accompany clients to a Pet-Friendly Shelter. These arrangements must be made in advance of the client's pick-up

Category storm you need transportation for 1 & 2 _____ 3 or higher _____ All _____

Are you a year round resident _____ or a seasonal resident _____ Name months you are in county _____

Can you sit up and ride in a bus or van? -----Y _____ N _____

Do you need a wheelchair lift? ----- Y _____ N _____

Do you require an ambulance for transportation? -----Y _____ N _____

(If yes, you will be contacted by Emergency Medical Services to assess your condition.)

Are you receiving home health care?-----Y _____ N _____

If yes, name of agency-- _____

If you have a required caregiver, please list their name and phone number.

Name _____ Phone number _____

Total number of people that will accompany you to a shelter _____

You must give name & phone number of a neighbor or friend that we may use for an alternate contact. his person must live in your area & must be aware that they are listed as an alternate contact!

Name _____ Phone _____

<p>*****TO BE FILLED OUT BY REFERRING AGENCY*****</p> <p>Agency Name: _____</p> <p>Location & Phone Number: _____</p> <p>New Client _____ Update Existing Client _____ Delete _____ (reason) _____</p>
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Please check all that apply:

About your condition:

Are you dependant on any of the following:

No Disabilities		<i>Catheters</i>	
Alzheimer's – Note Stage		<i>Electricity</i>	
Ameliorating Lateral Sclerosis ALS		<i>NG tube/CV infusion site/tracheostomy</i>	
Back Injury		<i>Insulin</i>	
Blind, Hearing or Speech Impaired		<i>I.V. Medication</i>	
Cerebral Palsy		<i>Oxygen</i>	
Colostomy or Ileostomy - Specify		<i>Respirator</i>	
Contagious Disease - Specify			
Epilepsy / Other Seizures - Specify		<i>Walker / Cane / Crutches</i>	
Fractured Bones with Pin Care		<i>Wheelchair on occasion</i>	
Full Paralysis		<i>Ambulatory(can get around on your own)</i>	
Heart Condition		<i>Ambulatory with assistance</i>	
High Blood Pressure		<i>Non-Ambulatory (bedridden)</i>	
Mental Illness - Specify		<i>Wheelchair bound</i>	
Special Diet - Specify			
Pregnant in 7 th month or More		<i>Dialysis -no dialysis available at shelter</i>	
Severe Arthritis		<i>Terminal Condition</i>	
Other Condition - Specify			

Is shelter assistance needed for (circle all that apply):

Communications, Feeding, Dressing Changes, or Medication

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet attached and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I also grant permission to emergency personnel to enter my home following an emergency if deemed necessary by proper authorities. I understand that this registration is voluntary and hereby request registration in the Special Needs Program. I understand that all information given will be held in strict confidence and will be used for emergencies only.

X _____ Date _____
 Signature of Client Date of Signature

***** FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE *****		
Evac zone _____	EMS Zone _____	Date contacted _____
Transport to: Hospital _____	Nursing Home _____	Special Needs Shelter _____
HIPAA Forms Y____ N____	Transport by: EMS _____	Social Service _____

Please return to the following: Monroe County Special Needs Registry
 1100 Simonton Street Room 1-180
 Key West, FL 33040