Revised 10/01/12

MANATEE COUNTY EMERGENCY MANAGEMENT
SPECIAL NEEDS PROGRAM QUESTIONNAIRE

Emergency Management is mandated by Florida Statutes to maintain a voluntary registry of persons who will need assistance during emergency evacuations. Records relating to registration of disabled citizens are exempt from the Provisions of F.S. 119.07(1), Public Records Law.

Please complete this form to register for the Special Needs Program and mail to:
Manatee County Emergency Management, P.O. Box 1000, Bradenton, FL 34206-1000 Phone 941-749-3500 x 7828

Transportation Registration

Last Name: _____ First: _____ MI: _____ Nick Name: _____ Phone: _____

Date of Birth: _____ Age: _____ SSN: XXX—XX—_____ Height: _____ ft. _____ in. Weight: _____ lbs.

Address: _____ City: _____ Zip: _____

1. ☐ House ☐ Manufactured Housing ☐ Apartment/Condo ☐ HUD Housing
☐ Hotel ☐ Independent Living Facility/Group Home ☐ Other: _____

Subdivision/Complex Name: _____

2. ☐ Own ☐ Rent **3.** Primary Language ☐ English ☐ Spanish ☐ Other: _____

4. Do you live alone? ☐ Yes ☐ No If no, with whom do live? _____

BUS TRANSPORTATION WILL TRANSPORT TO A GENERAL POPULATION SHELTER OR SPECIAL NEEDS SHELTER.

AMBULANCE TRANSPORTATION WILL **ONLY** GO TO A HOSPITAL OR NURSING HOME.

☐ Own Transportation ☐ Bus/Handy-Bus ☐ Ambulance is Required

Special Needs Shelter Application

1. Dogs and cats are allowed at the Special Needs Shelter…….... Prior arrangements must be made.
2. Special diets are not provided……. Bring your own special diet food.
3. Limited numbers of Army cots are available……. Weight limit 250 lbs. Bring your own cot.
4. Are you able to get up and down from a cot? ☐ Yes ☐ No

Bring a caregiver. Last Name: _____ First name: _____ Phone: _____

Total number of people sheltering with you (include yourself): _____

Do you have a service animal?	☐ Yes	☐ No	If yes, type of animal? _____ Type service: _____		
Do Not Resuscitate (DNR) status	☐ Yes	☐ No	DNR attached	☐ Yes	☐ No
Use a wheelchair	☐ Yes	☐ No	Are you confined to a bed	☐ Yes	☐ No
Use a cane or walker	☐ Yes	☐ No	On electrical support	☐ Yes	☐ No
C-PAP	☐ Yes	☐ No	On a respirator	☐ Yes	☐ No
Apnea Monitor	☐ Yes	☐ No	On a ventilator	☐ Yes	☐ No
Require oxygen _____Liters/Min.	☐ Yes	☐ No	Have an oxygen regulator	☐ Yes	☐ No
Have an oxygen concentrator	☐ Yes	☐ No	Have a portable oxygen tank	☐ Yes	☐ No
Oxygen concentrators must be brought to the Special Needs Shelter! Assistance will be provided.					
Require a nebulizer	☐ Yes	☐ No	Require Dialysis? _____ times per week	☐ Yes	☐ No
Receiving I.V. infusion	☐ Yes	☐ No	Dialysis type ☐ Peritoneal	☐ Hemodialysis	
Have/require dressing changes	☐ Yes	☐ No	NG Tubes/colostomy	☐ Yes	☐ No
Immune suppression	☐ Yes	☐ No	Central Venous line	☐ Yes	☐ No
Indwelling catheter	☐ Yes	☐ No	Tube feeding	☐ Yes	☐ No
Have a tracheostomy	☐ Yes	☐ No	Suction equipment	☐ Yes	☐ No
Incontinent	☐ Yes	☐ No	Medication requiring refrigeration	☐ Yes	☐ No
Alzheimer's disease	☐ Yes	☐ No	Dementia	☐ Yes	☐ No
Attention deficit hyperactivity disorder	☐ Yes	☐ No	Obsessive compulsive disorder	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Conduct disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Depression	☐ Yes	☐ No
☐ Legally Blind ☐ Deaf	☐ Mute		Assistive Device	☐ Yes	☐ No
I authorize emergency response personnel to enter my home for search and rescue operations.				☐ Yes	☐ No

Signature of the person requesting assistance and/or sheltering. **Date:**

DISCHARGE PLANNING INFORMATION

In the event that your home is damaged and you are not able to return home, this information will be used to assist Department of Elder Affairs in finding you a place to stay.

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Age:** _____ **Social Security Number:** **XXX—XX—** _____

Insurance Information and ID Number(s):

☐ Medicare:	☐ Medicaid:
☐ Champus:	☐ Private Insurance:
☐ TriCare for Life:	☐ Other:

Veteran ☐ Yes ☐ No

1. If someone calls to inquire if you are in this shelter, do we have permission to tell them you are here? ☐ Yes ☐ No
2. Do we have permission to tell them where you have relocated once you leave the shelter? ☐ Yes ☐ No

Signature: **Date:**

POST EVENT PLANNING

1. If you can't return home when the shelter closes, do you have an alternative plan for housing? ☐ Yes ☐ No
2. If yes, where will you go? _____
   Contact information for relocation site Name:_____ Phone: _____
   Street Address: City: State:
3. Do you have transportation? ☐ Yes ☐ No If yes, describe:
4. **Do you receive services from a Physician or Outside Agency?** ☐ Yes ☐ No

   If Yes**, Primary Physician:** ☐ Yes ☐ No **Physician's Name:** _____
   Contact: Phone:

   If Yes**, Hospice:** ☐ Yes ☐ No **Agency's Name:** _____
   Contact: Phone:

   If Yes**, Home Health:** ☐ Yes ☐ No **Agency's Name:** _____
   Contact: Phone:

   If Yes**, Nurse Registry:** ☐ Yes ☐ No **Agency's Name:** _____
   Contact: Phone:

   If Yes**, Oxygen Provider:** ☐ Yes ☐ No **Agency's Name:** _____
   Contact: Phone:

   If Yes**, Medical Equipment Provider:** ☐ Yes ☐ No **Agency's Name:** _____
   Contact: Phone:

   If Yes**, Dialysis Provider:** ☐ Yes ☐ No **Agency's Name:** _____
   Contact: Phone:

   If Yes**, Pharmacy:** ☐ Yes ☐ No **Pharmacy's Name:** _____
   Contact: Phone:

5. **Local Emergency Contact**: _____ Phone: _____
   Relationship: _____
   Address: City: State:
6. **Non-Local Emergency Contact:** _____ Phone: _____
   Relationship: _____
   Address: City: State:
7. **Do you have a pet?** ☐ Yes ☐ No
   Type and Number ☐ Dog(s) # _____ ☐ Cat(s) # _____ ☐ Other Type(s) _____
   Veterinarian's Name:_____
   Address: City: State:
8. **Email Address:** ☐ Yes ☐ No If yes, _____

MEDICAL PROFILE

Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ SSN: XXX—XX—_____

List all allergies: _____

List all medical conditions:

1.	**9.**
2.	**10.**
3.	**11.**
4.	**12.**
5.	**13.**
6.	**14.**
7.	**15.**
8.	**16.**

_____ _____

Signature of person/agency completing form Date

FOR OFFICIAL USE ONLY **Pre-registered ☐** **FOR OFFICIAL USE ONLY**