BROWARD COUNTY SPECIAL MEDICAL NEEDS SHELTER AND EVACUATION TRANSPORTATION 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: _____ ZIP: _____

Mailing Address (if different than above):_____

Phone #: _____ Alternate Phone #_____

Primary Language:_____

Living Situation: ☐ Alone ☐ Relative ☐ Care giver ☐ Other_____

Emergency Contacts: Local: _____Relationship: _____ Phone: _____

Non - Local: _____Relationship: _____ Phone: _____

EVACUATION TRANSPORTATION ASSISTANCE

I Require Transportation: ☐ Yes ☐ No

Transportation Needs: ☐ Ambulatory ☐ Wheelchair ☐ Other Transportation (Specify):_____

☐ Additional Information (Incl. Equipment):_____

Number of Persons to be Transported from this Residence: _____ Total Number of Persons Needing Wheelchair Transport:_____

☐ Mental Health Issues: _____ ☐ Cognitive Impaired:_____ (i.e., Alzheimer's, Dementia) Specify: _____	List any Assistive Devices Such as Glasses, White Cane, Hearing Aid: _____ ☐ Vision Loss/ Impaired _____ ☐ Hearing Loss/Impaired _____ ☐ ASL ☐ Speech Impaired _____
☐ Mobility Impaired ☐ Walker ☐ Cane ☐ Wheelchair ☐ Crutches ☐ Other: _____	☐ Service Animal(s) Number and Type of Animal:_____ 1. Is Client Disabled? (Y/N)_____ 2. Is the Animal Trained (Y/N)?_____ 3. What Does the Animal do for the Client? _____

ALTERNATIVE FORMATS OF THIS APPLICATION ARE AVAILABLE UPON REQUEST

IF THE APPLICATION IS TO REQUEST EVACUATION TRANSPORTATION ASSISTANCE ONLY, YOU ARE NOT REQUIRED TO COMPLETE THE INFORMATION ON PAGE 2—PLEASE TURN TO PAGE 3.

BROWARD COUNTY SPECIAL MEDICAL NEEDS SHELTER AND EVACUATION TRANSPORTATION ASSISTANCE APPLICATION

SPECIAL MEDICAL NEEDS OF APPLICANT *(To be Completed by Physician, R.N., or Case Manager)*

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

Will You be Accompanied to the Shelter? ☐ Yes ☐ No

If "Yes", Number of Care Givers/ Family Members Accompanying Individual to the Shelter: _____

Medically Dependent On Electricity: ☐ O2 Concentrator ☐ Feeding Pump ☐ Suction ☐ Medication Requiring Refrigeration ☐ Other: _____	Oxygen Dependent: ☐ 24 Hour ☐ Only Overnight ☐ Intermittent Oxygen Type: _____ Mode of Administration: ☐ Nasal Cannula ☐ Mask Liters Flow: _____ L /Minute_____
☐ Assistance With Medication Administration ☐ Insulin Dependent ☐ Assistance Needed With Wound Care. Specify:_____	☐ Incontinence ☐ Bowel ☐ Bladder ☐ Dialysis Dependent ☐ Peritoneal (PD) ☐ Hemodialysis Schedule:_____
☐ Special Diet (Explain): _____ _____	☐ Other Health Impairments: _____ _____

Medical Information:

Primary Doctor: _____ Phone: _____

Home Health Agency: _____ Phone: _____

Home Medical Equipment (HME) Provider: _____ Phone: _____

Oxygen Company (if different than HME): _____ Phone: _____

Dialysis Center: _____ Phone:_____

Pharmacy_____ Phone:_____

Name of Hospice:_____ Phone:_____

List Routine Medications (Both Prescription and Over-the-Counter):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List All Medical Conditions and Allergies:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

To the best of my knowledge, the information included in the above medical information section is correct and complete.

Physician or Medical Provider Printed Name:_____

Signature of Physician or Medical Provider:_____ Date Signed:_____

BROWARD COUNTY SPECIAL MEDICAL NEEDS SHELTER AND EVACUATION TRANSPORTATION ASSISTANCE APPLICATION

By signing this form I give my authorization for medical information contained herein to be released to the Broward County Human Services Department, State of Florida Department of Health, Broward Health, Memorial Health Care System, State of Florida Children's Medical Services, emergency management, and receiving facilities for the purpose of evaluating my needs and providing transportation and sheltering. Records relating to registration of disabled persons are exempt from the provisions of F.S. 119.07 (1), Public Records Law. Except as otherwise provided by this authorization, the information you provide will be kept confidential.

Signature (Applicant or Responsible Person for the Applicant): _____

Print Name:_____ Date:_____

DO NOT WRITE BELOW THIS LINE—FOR INTERNAL USE ONLY

Shelter Type:_____Shelter Name: _____Database/Record#:_____

Application Update: Month/Year:_____ Month/Year:_____ Month/Year:_____

TRANSPORTATION PLANNING

VERIFIED TRANSPORTATION NEEDS: ☐ Yes ☐ No

Transportation Type Assigned: ☐ Ambulatory ☐ Wheelchair ☐ ESF-8