



Florida Special Needs Registry Registration Information - Broward County

Instructions: Complete this form and fax or mail it to Broward County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered on line. Required fields are indicated with an asterisk (*).

Mail: Broward County Special Needs Registry
ATTN: Special Needs Shelter Coordinator
201 NW 84th Ave
Plantation, FL 33324

Fax: (888) 888-8888

PERSONAL INFORMATION ABOUT THE REGISTRANT

*First Name	
Middle Name	
*Last Name	
Suffix	
*Birth Date	
*Gender (select only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer Not To Provide
*Height	Feet: Inches:
*Weight (pounds)	
Living Situation (select only one)	<input type="checkbox"/> Live alone <input type="checkbox"/> Live with relative or caregiver <input type="checkbox"/> Other living situation
*Primary Language	
Secondary Language	
Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last 4 digits of SSN	
Email Address	
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	<input type="checkbox"/> Family Member <input type="checkbox"/> Caregiver <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Health Care Provider <input type="checkbox"/> County Emergency Management Staff <input type="checkbox"/> County Health Department Staff <input type="checkbox"/> DOH State Staff

ADDRESS FOR THE REGISTRANT (physical address is required)

*Physical Address (cannot be a PO Box)	
Apt #, Unit #, Bldg #, Suite #, etc.	
*Physical City	
*Physical State	FL
*Physical Zip Code	
Name of Complex, Subdivision or Mobile Home Park	
Is the home at this address a mobile home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the home at this address a highrise or multi-story home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this home have stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a code required to enter?	



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ADDRESS FOR THE REGISTRANT (physical address is required)

Do you live at this address year round?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If No, from month: _____ To month: _____
Mailing Address (if different from above)			
Mailing City			
Mailing State			
Mailing Zip Code			

Additional County Information

What is the gate code?	
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PHONE NUMBERS FOR THE REGISTRANT (a primary and at least one other phone number is required)

*Phone Number	Extension	*Phone Type (select only one)	Primary	TTY/TDD Capable
() -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
() -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
() -		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRIMARY EMERGENCY CONTACT FOR THE REGISTRANT (required)

*Primary Emergency Contact Name	
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Secondary Phone Number	() - Extension:
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Email Address	

OTHER CONTACTS FOR THE REGISTRANT (entry is optional)

*Other Contact Name	
*Contact Type (select only one)	<input type="checkbox"/> Secondary Emergency Contact <input type="checkbox"/> Caregiver <input type="checkbox"/> Family Member <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Pharmacy <input type="checkbox"/> Home Health Care Provider <input type="checkbox"/> Home Medical Equipment Provider <input type="checkbox"/> Hospice Provider <input type="checkbox"/> Oxygen Provider <input type="checkbox"/> Dialysis Clinic <input type="checkbox"/> Other Medical Provider <input type="checkbox"/> Out Of Area Contact <input type="checkbox"/> Alternate Living Arrangement Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	() - Extension:



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OTHER CONTACTS FOR THE REGISTRANT (entry is optional)

Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Secondary Phone Number	() - Extension:	
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Email Address		
*Other Contact Name		
*Contact Type (select only one)	<input type="checkbox"/> Secondary Emergency Contact <input type="checkbox"/> Caregiver <input type="checkbox"/> Family Member <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Pharmacy <input type="checkbox"/> Home Health Care Provider <input type="checkbox"/> Home Medical Equipment Provider <input type="checkbox"/> Hospice Provider <input type="checkbox"/> Oxygen Provider <input type="checkbox"/> Dialysis Clinic <input type="checkbox"/> Other Medical Provider <input type="checkbox"/> Out Of Area Contact <input type="checkbox"/> Alternate Living Arrangement Contact	
Contact Address		
Contact City		
Contact State		
Contact Zip Code		
*Contact Primary Phone Number	() - Extension:	
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Secondary Phone Number	() - Extension:	
Is this phone TTY/TDD capable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Email Address		

Additional County Information

*Will a caregiver be accompanying you to the shelter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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REGISTRANT'S SERVICE ANIMALS

*Animal Type (select only one)	*Required Due to Disability	*Work or Task Animal has been trained to perform
<input type="checkbox"/> Dog <input type="checkbox"/> Miniature Horse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Dog <input type="checkbox"/> Miniature Horse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Dog <input type="checkbox"/> Miniature Horse	<input type="checkbox"/> Yes <input type="checkbox"/> No	

REGISTRANT'S EQUIPMENT

Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	<input type="checkbox"/> Apnea Monitor <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> CPAP / BiPAP <input type="checkbox"/> Dialysis Catheter <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Medication that requires refrigeration <input type="checkbox"/> Nebulizer <input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Suction Pump <input type="checkbox"/> Ventilator <input type="checkbox"/> Wound Vac			
	Other: _____			
Please indicate any medically necessary equipment that is NOT electric dependent for this registrant: (select all that apply)	<input type="checkbox"/> EpiPen <input type="checkbox"/> Indwelling Urinary Catheter (Foley) <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Peripheral Intravenous Line <input type="checkbox"/> PICC Line <input type="checkbox"/> Port-a-Cath <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Tracheostomy			



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Additional County Information	
What type of Ventilator is used?	
What are the Ventilator settings?	
Please list any other medically necessary equipment that is NOT electric dependent for this registrant	

TRANSPORTATION & MOBILITY	
Registrant has the following transportation needs: (select all that apply)	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> Needs transportation to a shelter</div> <div style="width: 25%;"><input type="checkbox"/> Can be transported in a car</div> <div style="width: 25%;"><input type="checkbox"/> Can be transported in a bus</div> <div style="width: 25%;"><input type="checkbox"/> Must be transported in a wheelchair accessible vehicle</div> <div style="width: 25%;"><input type="checkbox"/> Must be transported in a stretcher van</div> <div style="width: 25%;"><input type="checkbox"/> Uses a wheelchair but can transfer to a van seat</div> <div style="width: 25%;"><input type="checkbox"/> Weight requires special transportation</div> <div style="width: 25%;"><input type="checkbox"/> Needs continuous oxygen during transport</div> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Caregiver(s) needs transportation:</div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Other shelteree(s) needs transportation:</div>
Registrant has the following mobility issues: (select all that apply)	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> Needs help to walk</div> <div style="width: 25%;"><input type="checkbox"/> Needs help transferring to/from cot and/or mobility device</div> <div style="width: 25%;"><input type="checkbox"/> Uses a Hoyer Lift to get out of a cot</div> <div style="width: 25%;"><input type="checkbox"/> Is confined to a bed</div> <div style="width: 25%;"><input type="checkbox"/> Paraplegic</div> <div style="width: 25%;"><input type="checkbox"/> Quadriplegic</div> <div style="width: 25%;"><input type="checkbox"/> Uses a Walker</div> <div style="width: 25%;"><input type="checkbox"/> Uses a Cane</div> <div style="width: 25%;"><input type="checkbox"/> Uses a Wheelchair</div> <div style="width: 25%;"><input type="checkbox"/> Uses a Motorized Wheelchair / Scooter</div> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Other:</div>

Additional County Information	
*Are you registered with Broward County Paratransit (TOPS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, what is your TOPS Client ID Number?	
*Are you able to get to the curb outside of your residence on your own or by using your mobility aid/device?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*Does registrant require transportation to a shelter?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you use a wheelchair, do you require help transferring?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL & OTHER	
Behavioral: (select all that apply)	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> Anxiety</div> <div style="width: 25%;"><input type="checkbox"/> Autism</div> <div style="width: 25%;"><input type="checkbox"/> Bipolar</div> <div style="width: 25%;"><input type="checkbox"/> Combative / Violent</div> <div style="width: 25%;"><input type="checkbox"/> Conduct Disorder</div> <div style="width: 25%;"><input type="checkbox"/> Flight Risk</div> <div style="width: 25%;"><input type="checkbox"/> Obsessive / Compulsive</div> <div style="width: 25%;"><input type="checkbox"/> Personality Disorder</div> <div style="width: 25%;"><input type="checkbox"/> Psychosis</div> <div style="width: 25%;"><input type="checkbox"/> Schizophrenia</div> <div style="width: 25%;"><input type="checkbox"/> Self-injurious or danger to others</div> <div style="width: 25%;"><input type="checkbox"/> Substance Abuse</div> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Other:</div>
Memory: (select all that apply)	<input type="checkbox"/> Alzheimer's and related dementias <input type="checkbox"/> Dementia <input type="checkbox"/> Memory Impaired
Dialysis: (select all that apply)	<input type="checkbox"/> Hemodialysis (Facility/Home) <input type="checkbox"/> Peritoneal Dialysis
Name of Primary Insurance Company:	



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MEDICAL & OTHER																																					
Dialysis Frequency: (select only one)	<input type="checkbox"/> 1 time a week <input type="checkbox"/> 2 times a week <input type="checkbox"/> 3 times a week <input type="checkbox"/> 4 times a week <input type="checkbox"/> 5 times a week <input type="checkbox"/> 6 times a week <input type="checkbox"/> 7 times a week (daily)																																				
Insurance ID #:																																					
Oxygen Type: (select only one)	<input type="checkbox"/> Gaseous <input type="checkbox"/> Liquid																																				
Do you have a Do Not Resuscitate (DNR) order? IMPORTANT: If yes, please remember to bring the original yellow copy with you to the Special Needs Shelter.	<input type="checkbox"/> Yes <input type="checkbox"/> No																																				
Oxygen Liter Flow / Amount: (select only one)	<input type="checkbox"/> 0.5 <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/> 3.0 <input type="checkbox"/> 3.5 <input type="checkbox"/> 4.0 <input type="checkbox"/> 4.5 <input type="checkbox"/> 5.0 <input type="checkbox"/> 5.5 <input type="checkbox"/> 6.0 <input type="checkbox"/> 6.5 <input type="checkbox"/> 7.0 <input type="checkbox"/> > 7.0																																				
Oxygen Mode of Administration: (select only one)	<input type="checkbox"/> Mask <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Trach Collar																																				
Medicare #:																																					
Medicaid #:																																					
Medication Allergies & Reactions (list all)																																					
Do you need assistance with administering your medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No																																				
Other: (select all that apply)	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Vision Impaired</td> <td><input type="checkbox"/> Partially Blind</td> <td><input type="checkbox"/> Legally Blind</td> <td><input type="checkbox"/> Hearing Impaired</td> </tr> <tr> <td><input type="checkbox"/> Deaf</td> <td><input type="checkbox"/> ALS</td> <td><input type="checkbox"/> Arthritis / Osteoporosis</td> <td><input type="checkbox"/> Angina</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Cerebral Palsy</td> <td><input type="checkbox"/> Congestive Heart Failure</td> </tr> <tr> <td><input type="checkbox"/> COPD</td> <td><input type="checkbox"/> Cystic Fibrosis</td> <td><input type="checkbox"/> Diabetes (Type 1)</td> <td><input type="checkbox"/> Diabetes (Type 2)</td> </tr> <tr> <td><input type="checkbox"/> Incontinent</td> <td><input type="checkbox"/> IV Pump</td> <td><input type="checkbox"/> Non verbal</td> <td><input type="checkbox"/> Difficulty understanding verbal instructions</td> </tr> <tr> <td><input type="checkbox"/> Difficulty speaking</td> <td><input type="checkbox"/> Emphysema</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Hypertension (High Blood Pressure)</td> </tr> <tr> <td><input type="checkbox"/> Hypotension (Low Blood Pressure)</td> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> MS</td> <td><input type="checkbox"/> Muscular Dystrophy</td> </tr> <tr> <td><input type="checkbox"/> Colostomy</td> <td><input type="checkbox"/> Ileostomy</td> <td><input type="checkbox"/> Urostomy</td> <td><input type="checkbox"/> Pacemaker / AICD</td> </tr> <tr> <td><input type="checkbox"/> Parkinsons</td> <td><input type="checkbox"/> Peritoneal Dialysis Pump</td> <td><input type="checkbox"/> Stroke</td> <td></td> </tr> </table> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Bedsore (Decubitus Ulcer):</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Contagious Disease:</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Food Allergies & Reactions:</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Seizures:</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Other:</div>	<input type="checkbox"/> Vision Impaired	<input type="checkbox"/> Partially Blind	<input type="checkbox"/> Legally Blind	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Deaf	<input type="checkbox"/> ALS	<input type="checkbox"/> Arthritis / Osteoporosis	<input type="checkbox"/> Angina	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> COPD	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Diabetes (Type 1)	<input type="checkbox"/> Diabetes (Type 2)	<input type="checkbox"/> Incontinent	<input type="checkbox"/> IV Pump	<input type="checkbox"/> Non verbal	<input type="checkbox"/> Difficulty understanding verbal instructions	<input type="checkbox"/> Difficulty speaking	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Hypotension (Low Blood Pressure)	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> MS	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Ileostomy	<input type="checkbox"/> Urostomy	<input type="checkbox"/> Pacemaker / AICD	<input type="checkbox"/> Parkinsons	<input type="checkbox"/> Peritoneal Dialysis Pump	<input type="checkbox"/> Stroke	
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REGISTRANT'S MEDICATION (Use additional paper if more space needed)			
*Name of Medication	Dosage	Route	Requires Refrigeration



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REGISTRANT'S MEDICATION (Use additional paper if more space needed)

*Name of Medication	Dosage	Route	Requires Refrigeration
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal <input type="checkbox"/> Inhaled	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal <input type="checkbox"/> Inhaled	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal <input type="checkbox"/> Inhaled	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal <input type="checkbox"/> Inhaled	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal <input type="checkbox"/> Inhaled	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal <input type="checkbox"/> Inhaled	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Auto Injector <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Mouth <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Sublingual <input type="checkbox"/> Transdermal <input type="checkbox"/> Inhaled	<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER NOTES ABOUT THE REGISTRANT



**Florida Special Needs Registry
Registration Information - Broward County**

OTHER NOTES ABOUT THE REGISTRANT