BROWARD COUNTY
SPECIAL NEEDS SHELTER AND
EVACUATION TRANSPORTATION ASSISTANCE
APPLICATION

INFORMATION AND INSTRUCTIONS

The Special Needs Shelter and Evacuation Transportation Assistance Program offers transportation and shelter for residents that do not have a safe place to be during dangerous weather or other emergencies, or do not have a way to get to the shelter. **Residents of any residential facility (e.g., Assisted Living Facilities, Nursing Homes, etc.) do not qualify for this program, because these business entities must have their own emergency evacuation plans in place for their clients.** If possible, arrange to evacuate with family, friends, or lodging out of harm's way for your "Plan A". A shelter should be your "Plan B".

Please understand that a shelter is a place of refuge of last resort from dangerous weather or other emergencies. While basic services such as food, electricity, and medical supervision will be provided at the shelters, clients and caregivers must provide supplemental food and all medications for three (3) to five (5) days.

General Population Shelters are located in buildings with large open areas, such as schools, and are a good fit for anyone who is self-sufficient and needs no outside assistance in performing activities of daily living. You will be provided floor space only, so you must bring everything you need to shelter, such as bedroll, lawn chair, pillow, blanket, clothes, etc. Food and water will be provided but it would be wise to bring some of your own, as well. Shelters will be crowded, and with a large storm, may fill up quickly.

Special Needs Shelters are located in schools, as well, and are for individuals whose medical conditions cannot be managed in a General Population Shelter. Electricity is provided for medical equipment. You must have an adult companion/caregiver accompany and assist you during sheltering. You must bring your medical equipment, medicines, personal items, money, etc. Your adult companion/caregiver must bring the same things, plus something to sleep on, such as a cot or lawn chair. We plan to have cots for those registered, but in a catastrophic storm our supplies will run out, so bring the things you cannot do without. Your service animal may shelter with you. You must bring crate/carrier, leash & collar, food, clean-up supplies, vaccination record, and any other comfort items for pets.

Higher Level of Care shelter spaces in medical management facilities (e.g., hospitals) are assigned to people whose health issues are unmanageable in a Special Needs Shelter. Sheltering will be in hallways, meeting rooms, or other large congregate spaces, and no medical attention will be provided. **You MUST have an adult companion/caregiver shelter with you the entire time.** You must bring your medical equipment, medicines, personal items, money, food (food is available for purchase), etc. Your caregiver will need to bring the same items, plus something to sleep on. You may NOT bring your pets or emotional support animals to shelter at the hospital (**ONLY Service Animals**).

Transportation to shelters can be pre-arranged by completing this application.

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Please note that all Broward County residents are expected to make their own plans to evacuate with their families and pets. It is important that everyone be responsible for their own safety and make a plan that includes where to go, who to contact, what to bring, and how to get there. However, the County realizes that some individuals may need assistance. Individuals meeting one of the following categories are eligible for assistance from the County:

- Those who require specialized transportation and/or have no transportation; or
- Those whose medical needs prevent them from evacuating on their own.

Please note that upon processing your application, a representative from the Broward Emergency Management Division (BEMD) and/or Department of Health (DOH) – Broward will contact you if further clarification is necessary.

What You Should Know to be Evacuation Ready

- **DO NOT** wait until an evacuation order is given to request being added to the registry.
  - *Resources are limited and pre-registered clients will have priority when an emergency arises.*
- Special Needs Shelters do not offer the same level of care equipment available at health care facilities.
- You must have a companion/caregiver accompany and assist you during sheltering.
- You must bring your medical equipment, medicines, personal items, money, etc.
- If you have a special diet, bring those dietary items with you to ensure the highest level of comfort.

ALL SECTIONS OF THIS APPLICATION MUST BE COMPLETED.

FOR APPLICANTS THAT MEET THE CRITERIA OF HIGHER LEVEL OF CARE, A NEW APPLICATION MUST BE SUBMITTED EVERY YEAR.

If more than one person in your household requires medical assistance during evacuations, each person must complete a separate application. Special instructions will be mailed to you once your application has been approved.

Should you have any questions, please call BEMD at 954-831-3902.

Please keep a copy of the completed application for your records and mail the original to:

Broward Emergency Management Division
ATTN: Special Needs Shelter and Evacuation Transportation Assistance Program
201 NW 84th Avenue, Plantation, FL 33324

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INSTRUCTIONS:

Complete this form and 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 online. Required fields are indicated with an asterisk (*).

PLEASE PRINT CLEARLY

Mail: Broward Emergency Management Division
ATTN: Special Needs Shelter and Evacuation Transportation Assistance Program
201 NW 84th Avenue
Plantation, FL 33324

PERSONAL INFORMATION ABOUT THE REGISTRANT	
*First Name	
Middle Name	
*Last Name	
Suffix	
*Birth Date	
*Gender (select only one)	☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer Not To Provide
*Height	Feet: Inches:
*Weight (pounds)	
Living Situation (select only one)	☐ Live alone ☐ Live with relative or caregiver ☐ Other living situation
*Primary Language	
Secondary Language	
Veteran	☐ Yes ☐ 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)	☐ Family Member ☐ Caregiver ☐ Neighbor ☐ Friend ☐ Home Health Care Provider ☐ County Emergency Management Staff ☐ County Health Department Staff ☐ DOH State Staff
Additional County Information	
*Name of Person completing this form on behalf of registrant	
Phone Number of Person completing this form on behalf of the registrant	
*If Other Living Situation was selected, please describe	

ADDRESS FOR THE REGISTRANT (physical address is required)	
*Physical Address (cannot be a PO Box)	
*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?	☐ Yes ☐ No

Florida Special Needs Registry
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ADDRESS FOR THE REGISTRANT (physical address is required)	
Is the home at this address a highrise or multi-story home?	☐ Yes ☐ No
Does this home have stairs?	☐ Yes ☐ No
Is there a gate that requires a code to enter?	☐ Yes ☐ No
Do you live at this address year round?	☐ Yes ☐ 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?	

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
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	
OTHER CONTACTS FOR THE REGISTRANT (Required)	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact
Contact Address	

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OTHER CONTACTS FOR THE REGISTRANT (entry is optional)	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	

REGISTRANT'S SERVICE ANIMALS			
*Animal Type (select only one)		*Required Due to Disability	*Work or Task Animal has been trained to perform
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	

REGISTRANT'S EQUIPMENT	
Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	☐ Apnea Monitor ☐ Cardiac Monitor ☐ CPAP / BiPAP ☐ Dialysis Catheter ☐ Feeding Pump ☐ Medication that requires refrigeration ☐ Nebulizer ☐ Oxygen Concentrator ☐ Suction Pump ☐ Ventilator ☐ Wound Vac Other:

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REGISTRANT'S EQUIPMENT	
Please indicate any medically necessary equipment that is NOT electric dependent for this registrant: (select all that apply)	☐ Indwelling Urinary Catheter ☐ Insulin Pump ☐ Peripheral Intravenous Line ☐ PICC Line ☐ Port-a-Cath ☐ Pulse Oximeter ☐ Tracheostomy
Additional County Information	
*Type of Ventilator	
*Ventilator Setting	
*OTHER medically necessary equipment that is NOT electric dependent for this registrant, please specify	

TRANSPORTATION & MOBILITY	
Registrant has the following transportation needs: (select all that apply)	☐ Can be transported in a car ☐ Can be transported in a bus ☐ Must be transported in a wheelchair accessible vehicle ☐ Must be transported in a stretcher van ☐ Uses a wheelchair but can transfer to a van seat ☐ Weight requires special transportation ☐ Needs continuous oxygen during transport ☐ Just needs transportation to a shelter
Registrant has the following mobility issues: (select all that apply)	☐ Needs help to walk ☐ Needs help to get into/out of a cot ☐ Uses a lift to get out of a cot ☐ Is confined to a bed ☐ Is paralyzed (complete or partial) ☐ Uses a Walker ☐ Uses a Cane ☐ Uses a Wheelchair ☐ Uses a Motorized Wheelchair / Scooter Other:
Additional County Information	
*OTHER Registrant has the following transportation needs, please specify	
*Are you registered with Broward County Paratransit (TOPS)?	☐ Yes ☐ No
*If Yes, What is your TOPS Client ID Number?	
*If you use a Wheelchair, do You require help transferring?	☐ Yes ☐ No
*Are you able to get to the curb outside your home without any assistance?	☐ Yes ☐ No

MEDICAL & OTHER	
Behavioral: (select all that apply)	☐ Autism ☐ Bipolar ☐ Combative / Violent ☐ Conduct Disorder ☐ Obsessive / Compulsive ☐ Personality Disorder ☐ Psychosis ☐ Schizophrenia ☐ Self-injurious or danger to others ☐ Substance Abuse Other:
Memory: (select all that apply)	☐ Alzheimer and related dementias ☐ Dementia ☐ Memory Impaired
Dialysis: (select all that apply)	☐ Hemodialysis (Facility/Home) ☐ Peritoneal Dialysis

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MEDICAL & OTHER	
Dialysis Frequency: (select only one)	☐ 1 time a week ☐ 2 times a week ☐ 3 times a week ☐ 4 times a week ☐ 5 times a week ☐ 6 times a week ☐ 7 times a week (daily)
Oxygen Type: (select only one)	☐ Gaseous ☐ Liquid
Oxygen Liter Flow / Amount: (select only one)	☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ 3.5 ☐ 4.0 ☐ 4.5 ☐ 5.0 ☐ 5.5 ☐ 6.0 ☐ 6.5 ☐ 7.0
Oxygen Mode of Administration: (select only one)	☐ Mask ☐ Nasal Cannula ☐ Trach Collar
Medication Allergies & Reactions (list all)	
Do you need assistance with administering your medications?	☐ Yes ☐ No
Other: (select all that apply)	☐ Vision Impaired ☐ Partially Blind ☐ Legally Blind ☐ Hearing Impaired ☐ Deaf ☐ ALS ☐ Arthritis / Osteoporosis ☐ Anxiety ☐ Angina ☐ Asthma ☐ Bedsore (Decubitus Ulcer) ☐ Cancer ☐ Cerebral Palsy ☐ Congestive Heart Failure ☐ COPD ☐ Cystic Fibrosis ☐ Diabetes ☐ Incontinent ☐ IV Pump ☐ Flight Risk ☐ Non verbal ☐ Difficulty understanding verbal instructions ☐ Emphysema ☐ Heart Disease ☐ High Blood Pressure ☐ Kidney Disease ☐ MS ☐ Ostomy (Colostomy, Ileostomy, Urostomy) ☐ Pacemaker / AICD ☐ Parkinsons ☐ Peritoneal Dialysis Pump ☐ Seizures ☐ Stroke Contagious Disease: Food Allergies & Reactions: Other:
Name of Primary Insurance Company:	
Insurance ID #:	
Medicare #:	
Medicaid #:	
Additional County Information	
Dialysis Order	
Oxygen Liter Flow / Amount, IF OTHER	

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

*Name of Medication	Dosage	Route	Requires Refrigeration
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No

REGISTRANT'S MEDICATION (Use additional paper if more space needed)			
*Name of Medication	Dosage	Route	Requires Refrigeration
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No

OTHER NOTES ABOUT THE REGISTRANT

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IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING

1. The information contained herein is true and correct to the best of my knowledge. I understand that if accepted, assistance will be provided only for the duration of the emergency, and that alternative arrangements should be made in advance in case I am unable to return to my home.
2. I understand that based on this application and the information I have provided, Florida Department of Health in Broward County, along with the Broward County Emergency Management Division, will determine which sheltering and emergency evacuation assistance, if any, this program may be able to provide.
3. I understand that the registration is voluntary and hereby request registration in the Special Needs Shelter and Evacuation Transportation Assistance Program.
4. Emergency shelters, including Special Needs Shelters, are made available to provide me protection and should be considered a **shelter of last resort** (if no other options are available).
5. I am required to bring a caregiver while at the shelter.
6. Limited nursing, medical assistance, supplies and equipment at the Special Needs Shelters will be available to assist me and/or my caregiver.
7. I will be responsible for any charges and costs associated with hospitalizations or other medical facilities including care and medical transportation if they should become needed.
8. **Transportation:** I may be asked to evacuate my residence. All attempts will be made to give advance notice by phone, of the date and time to expect to be picked up for transport to a shelter. If I decline transportation when the transporter arrives, I understand that I may not have another opportunity to request this service.
9. By signing this form I give my authorization for medical information contained herein to be released to the Broward County Human Services Department, Florida Department of Health in Broward County, Memorial Health Care System, Holy Cross Hospital, Broward Health, Cleveland Clinic and other hospitals, medical facilities and providers, the Broward County Transit Division, and the Broward County Emergency Management Division, for the purpose of evaluating my needs and providing transportation and sheltering. Records relating to registration of disabled citizens 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 of Applicant / Guardian / Authorized Caregiver / Person Completing the Application	**Date**
Printed Name	**Phone Number**

Completed applications must be mailed to:
Broward Emergency Management Division
ATTN: Special Needs Shelter and Evacuation Transportation Assistance Program
201 NW 84th Avenue, Plantation, FL 33324