



Broward County – Special Needs Shelter and Evacuation Transportation Assistance Application

Section 1.

CLIENT CONTACT INFORMATION

ALL QUESTIONS MUST BE ANSWERED IN ORDER FOR YOUR REQUEST TO BE PROCESSED.

Form for client contact information including fields for last name, first name, MI, physical address, development/subdivision, city, ZIP, residence type, mailing address, living situation, D.O.B., age, gender, weight, communication, primary/secondary telephone, language, and race/ethnicity.

Section 2. EMERGENCY CONTACT INFORMATION

I prefer not to provide this information

Form for emergency contact information with two sections for contact #1 and contact #2, including fields for name, relationship, address, telephone numbers, and a checkbox for medical information sharing.

With the exception of e-mail addresses, records relating to registration of persons requiring functional needs support are exempt from the provisions of F.S. 119.07 (1), Public Records Law.

Last Name: _____ First Name: _____ Middle Initial _____

SECTION 3. EVACUATION TRANSPORTATION ASSISTANCE

Are you registered with TOPS? Yes ___ No ___ If yes, what is your PIN number? _____

1. Do you require transportation to a shelter? () YES () NO
2. If you answered "Yes" yes to Question #1, do you have any special requirements, for example do you require assistance transferring from a bed to a wheelchair? _____
3. How far can you travel on your own or using your mobility aid?
 - a. ___ I cannot get outside my residence
 - b. ___ I can get to the curb outside my residence
4. **MOBILITY:** Please check off ALL that apply to you:

() Able to walk without aid () Bedbound () Cane () Crutches () Electric Wheelchair
 () Deaf/Hearing loss () Manual Wheelchair () Power Scooter () Blind/Vision loss () Walker
5. Do you have a service animal? Yes () No ()
6. Are you able to sleep on a portable medical cot (see information below)? ___ Yes ___ No



1. 18 inches high (wheelchair height)
2. 32 inches wide X 80 inches long

7. If you are bedbound, are you able to transfer to a wheelchair using a special lift? Yes ___ No ___
 8. Will anyone be accompanying you to the shelter? Yes ___ No ___
 If Yes, name/relationship: _____
 9. Do you require assistance from the attendant when walking? Yes ___ No ___
- Total number of persons to be transported from this address? _____
- Number of persons requiring wheelchair _____

CONTINUE TO THE NEXT PAGE

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SECTION 4. CLIENT MEDICAL HISTORY (For Physician Use Only)

- 1. THIS FORM IS ONLY FOR THE USE OF YOUR PRIMARY CARE PHYSICIAN.**
- 2. Your PRIMARY CARE PHYSICIAN must complete this section in its entirety and sign at the end.**
- 3. ALL sections require a response.**

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

<p>COGNITIVE ASSESSMENT () N/A <input type="checkbox"/> Alzheimer's/Dementia (all levels) (requires caregiver to accompany to shelter) <input type="checkbox"/> Anxiety () Aphasia () Autism <input type="checkbox"/> Conduct disorder () Depression <input type="checkbox"/> Obsessive compulsive disorder <input type="checkbox"/> Psychosis ___ Controlled ___ Uncontrolled (requires caregiver to accompany to shelter) <input type="checkbox"/> Seizures ___ Controlled ___ Uncontrolled <input type="checkbox"/> Other psychiatric diagnosis: _____</p>	<p>OXYGEN DEPENDENT () N/A Oxygen provider: _____ Telephone #: _____ <input type="checkbox"/> 24-hour () Overnight <input type="checkbox"/> Intermittent Number of hours/day _____ <input type="checkbox"/> Concentrator () Portable tank Mode of administration: () Nasal cannula () Mask <input type="checkbox"/> Liquid () Cylinder Liters flow/minute _____ (maximum is 4 L/minute)</p>
<p>ELECTRIC DEPENDENT () N/A <input type="checkbox"/> Apnea monitor () BPAP () CPAP <input type="checkbox"/> Respirator () Cardiac monitor <input type="checkbox"/> Feeding tube/pump <input type="checkbox"/> IV Name of medication: _____ _____ <input type="checkbox"/> Medication requiring refrigeration Name of medication: _____ <input type="checkbox"/> Nebulizer () Suction pump () Ventilator <input type="checkbox"/> Other _____</p>	<p>SPECIAL CARE () N/A <input type="checkbox"/> Assistance with administering medication <input type="checkbox"/> Assistance with daily activities (bathing, dressing, feeding) <input type="checkbox"/> Assistance getting out of bed () Catheter <input type="checkbox"/> Requires constant nursing care () Contagious disease <input type="checkbox"/> Currently under care of hospice <input type="checkbox"/> Dialysis _____ Number of times/week Facility ___ Home Dialysis ___ Peritoneal ___ <input type="checkbox"/> Incontinence ___ Bladder ___ Bowel <input type="checkbox"/> Wound/rash, open wound, requires dressing changes complex care</p>
<p>SPECIAL DIET () N/A _____ _____</p> <p>ALLERGIES () N/A _____ _____</p>	<p>OTHER HEALTH CONCERNS () N/A <input type="checkbox"/> COPD () Cardiac ___ stable ___ unstable <input type="checkbox"/> Frail/elderly () ALS () Parkinson's () Cancer <input type="checkbox"/> Diabetic ___ Insulin dependent ___ Non-insulin dependent ___ Speech impediment <input type="checkbox"/> Other: _____</p>
<p>PRESCRIPTION MEDICATION: _____ _____</p>	

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SECTION 4. CLIENT MEDICAL HISTORY (continued)

Please attach any additional documentation that you feel is necessary for the sheltering of this registrant.

Last Name: _____ First Name: _____ Middle Initial: _____

PHYSICIAN'S INFORMATION	ALL INFORMATION MUST BE PROVIDED
Name of physician: _____	Telephone: _____
Group Affiliation: _____	Hospital affiliation(s): _____
Address: _____	
City/State/Zip Code: _____	
To the best of my knowledge, the medical information provided in this section is correct and complete.	
Signature of physician: _____	Date: _____

MEDICAL SUPPORT CONTACT INFORMATION
Home Health Care Agency: _____
Point of contact: _____
Address: _____
Telephone No.: _____ Fax No.: _____
Caregiver's Full Legal Name: _____
Telephone No.: _____ Hours/day _____ Days/week _____
Pharmacy: _____ Telephone No.: _____
Pharmacy Address: _____
Home Medical Equipment Provider: _____
Point of Contact: _____ Telephone No.: _____
Address: _____
Dialysis Center: _____
Point of Contact: _____ Telephone No.: _____
Address: _____
Hospice: _____
Point of Contact: _____ Telephone No.: _____
Address: _____

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**Broward County Special Needs Emergency Shelter and Evacuation
Transportation Assistance Application
STATEMENT OF UNDERSTANDING AND SIGNATURE AUTHORIZATION FOR USE AND
DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

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.

I understand that based on this application and the data I have provided, Florida 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.

I understand that this registration is voluntary and hereby request registration in the Broward County Special Needs Shelter and Evacuation Transportation Assistance Program.

By signing this form I give my authorization for medical information contained herein to be released to the Broward County Human Services Department, Florida Health in Broward County, Memorial Health Care System, Holy Cross Hospital, Broward Health, 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. I give authorization for Broward County to resend page 2 of my application to the physician listed on an annual basis for update. I understand that changes to the information submitted requires completion of a new application and re-submittal. I further understand that if Broward County requests updated information or cannot contact me due to changes in my information they may remove me from the registry. This authorization shall remain in effect for 12 months from the date of signature.

With the exception of e-mail addresses, records relating to registration of persons requiring functional needs support 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.

Applicant/Patient Full Legal Name (PRINT): _____

Applicant/Patient Signature: _____ DATE: _____

If this authorization is signed by an individual's personal representative, or health care provider, on behalf of the individual, please complete the following:

Personal Representative's Full Legal Name (PRINT): _____

Contact Information (include telephone no.) _____

Relationship to the Individual: _____

Personal Representative's Signature: _____ DATE: _____

Completed applications must be mailed to:

**Broward Emergency Management Division
Attn: Special Needs Registry
201 NW 84th Avenue Plantation, FL 33324
954/831-3902**

If you have questions about this authorization, or to revoke this authorization prior to the expiration date or event, you must submit a written request to the above address.

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