Print Form | Reset Form

Indian River County
Special Needs Program Annual Application

Updated 02-2016

Complete one application per person. Please print clearly. You may be contacted by a member of the Emergency Services staff to review your application and answer any questions you may have.

APPLICANT INFORMATION

SS#	First Name:	Middle Initial:	Last Name:
Date of Birth: (Month-Day-Year)		Age:	Gender: ☐ Male ☐ Female
Physical Address: (Include Lot or Apt. #)		City: Vero Beach ☐ Sebastian ☐ Fellsmere ☐	
State: FL	Zip Code:	Primary Phone:	Secondary Phone:
		E-Mail Address:	

RESIDENCE

Private Home ☐ Apartment ☐ Condo ☐ **Manufactured/Mobile Home** ☐

Name of Complex, Subdivision, or Development:

Are you a full time resident of Indian River County? Yes ☐ No ☐

LOCAL MAILING ADDRESS (If different from address above)

Street Address:	City:	State:	Zip Code:

EMERGENCY CONTACT INFORMATION

Primary Contact:	Relationship:	Phone:
Secondary Contact:	Relationship:	Phone:

EVACUATION INFORMATION

TRANSPORTATION – Do you need transportation to a shelter? (please select one):

1. ☐ **Yes**, I need transportation. ☐ **No**, I will transport myself.
2. **If you answered yes above, what kind of vehicle do you require? (please select one):**
   ☐ Regular vehicle ☐ Wheelchair van ☐ Stretcher vehicle (ambulance)

CAREGIVER - If assistance is needed, each applicant is **REQUIRED** to be accompanied by one caregiver. **NAME:** Phone:

PETS – I need to register for the Humane Society's program to care for my pet(s) while I am at the Special Needs Shelter. **Yes** ☐ **No** ☐ **If yes, I have a Dog(s)** ☐ **and/or Cat(s)** ☐

MEDICAL INFORMATION

Are you a Hospice patient? ☐ Yes ☐ No

Name of home health care agency, if applicable:	Phone:

MEDICAL INFORMATION continued

Name of Pharmacy:	Phone:
Name of Primary Physician:	Phone:
Name of oxygen provider, if applicable:	Phone:

ALLERGIES

Allergies: Are you allergic or sensitive to any medication(s)? Yes ☐ No ☐

If yes, please explain which medications and what the reaction was:

MOBILITY:

- ☐ I can walk **without** assistance
- ☐ I walk **with** assistance
- ☐ I use a cane
- ☐ I use a walker
- ☐ I use a **standard** (non- electric) wheelchair
- ☐ I use an **motorized** wheelchair/scooter
- ☐ I am bedridden (require stretcher)
- ☐ I use a Hoyer lift

RESPIRATORY SUPPORT:

☐ I am oxygen dependent and understand that I must bring an ample supply of oxygen to get me to and from the shelter.

☐ I use a O2 Concentrator

___ As Needed
___ 24/7
___ Overnight

- ☐ I use a Nebulizer
- ☐ I use a CPAP
- ☐ I use a Ventilator
- ☐ I use a Suction Machine

GENERAL MEDICATION CONDITIONS:

☐ I use **Insulin** for ***DIABETES***
☐ I use **Oral Medication** for ***DIABETES***

☐ Paralysis ☐ Complete ☐ Partial

☐ Dialysis
☐ Home Dialysis ☐ Facility Dialysis
Number of times dialyzed per week: _____.
Name of dialysis center:

☐ Open wounds that require dressing changes. Times per day:

☐ Medications that require refrigeration?

- ☐ Severe arthritis
- ☐ High blood pressure
- ☐ Heart condition
- ☐ Blind/Vision impaired
- ☐ Deaf/Hearing impaired
- ☐ Service animal
- ☐ Incontinent ☐ Catheterized
- ☐ Ostomy
- ☐ Feeding tube
- ☐ **Alzheimer's/Other Dementias (Caregiver REQUIRED)**
- ☐ Electric Dependent **(O2, CPAP)**
- ☐ Other:

MEDICATIONS:
(Attach a separate sheet if necessary)

Prescription Medications			Over-the-counter (OTC) medications		
Rx Name	Dose	How Often	OTC Name	Dose	How Often

SPECIAL NOTES

As a special needs shelter evacuee, I am entitled to pre-authorize emergency response personnel to enter my home during search and rescue operations, if necessary, to assure my safety and welfare following a disaster as defined in Florida Statutes 252.34.

☐ Yes, I do pre-authorize. ☐ No, I will not pre-authorize.

☐ I understand that the Special Needs Shelter will not be air conditioned if emergency power is required.

☐ I understand that I need to bring with me all medications, in marked bottles, and all medical supplies I use for my care for up to 14-days (two weeks).

☐ I understand that I must bring my own bedding. The Special Needs Shelter will not supply cots or other bedding.

☐ Part of my emergency plan includes designating alternate living arrangements (home of friend or relative, etc.) in the event my home is severely damaged and I am unable to return.
My alternate plan is to temporarily reside at the following location:

☐ I understand that once this public shelter has been closed following the emergency event, it will be my responsibility to either return home or seek other living arrangements.

READ AND SIGNREAD AND SIGN***READ AND SIGN***READ AND SIGN***

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on this application and the data I have provided, the Department of Emergency Services will determine which emergency evacuation assistance, if any, this program may be able to provide. Further, I grant permission to medical providers, transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

Signature: ***Date:***

APPLICANT REPRESENTATIVE

If the person completing this form is not the applicant, please answer the following:

Name:	Relationship/Agency:	
Phone:( )	Applicant has been notified of this registration: Yes ☐ No ☐	

OFFICIAL USE ONLY

Reviewed By:	Date:	Category:	Sector #:
Applicant Contacted:	Pre-Registered: ☐Yes ☐No	Type of Stay: ☐ Patient ☐ Caregiver	
Type of Shelter: ☐ Regular ☐ SNS ☐Hospital ☐ Hospice		☐ Patient/Caregiver	

Click to submit form

Return Application to
IRC Dept. of Emergency Services (ATTN: SNS)
4225 43rd Avenue
Vero Beach, FL 32967

Questions? Call (772) 567-2154 On-Line form: www.irces.com