



Division of
Emergency Management

Palm Beach County Special Needs Shelter Application

APPLICATION DATE: _____

SHELTER INFORMATION

Thank you for your interest in the Palm Beach County Special Needs Shelter. Please understand that the 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; clients and caregivers must provide supplemental food and all medications for the first three days. The shelter cannot provide the appropriate care to ventilator, and certain other patients. Please see page three for accepted diagnoses.

Please remember: Bed height adjustable back hospital cots are provided for clients. Caregivers must provide their own sleeping arrangements.

CLIENT IDENTIFICATION

LAST: _____ FIRST: _____
DATE OF BIRTH: ____ / ____ / ____ HEIGHT: ____ FEET ____ INCHES WEIGHT: _____
GENDER: MALE or FEMALE LANGUAGE SPOKEN: _____
HOME PHONE: _____ CELL PHONE: _____

CLIENT RESIDENCE INFORMATION

ADDRESS: _____ APT/LOT #: _____
CITY: _____ ZIP: _____ E-MAIL: _____
MAILING ADDRESS: SAME AS ABOVE _____
CITY: _____ ZIP: _____
Do you live above the ground level? YES If yes, what floor? _____
DEVELOPMENT NAME: _____ GATE CODE: _____

DWELLING TYPE:
 SINGLE FAMILY DUP/MULTIPLEX
 MOBILE HOME APT/CONDO

CAREGIVER INFORMATION

Patients requiring a caregiver must be accompanied by their caregiver at all times.

Do you have a caregiver who will accompany you to the shelter? YES or NO

NAME: _____ RELATIONSHIP: _____ PHONE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

Does your caregiver have special needs? YES or NO If yes, explain: _____

EMERGENCY CONTACTS

(LOCAL) NAME: _____ RELATIONSHIP: _____ PHONE: _____
(NON-LOCAL) NAME: _____ RELATIONSHIP: _____ PHONE: _____

MEDICAL SUPPORT INFORMATION

PRIMARY DOCTOR: _____ PHONE: _____
 HOME HEALTH AGENCY: _____ PHONE: _____
 HOME MEDICAL EQUIPMENT PROVIDER: _____ PHONE: _____
 DIALYSIS CENTER: _____ PHONE: _____
 OXYGEN SUPPLIER: _____ PHONE: _____

TRANSPORTATION

Do you need transportation to a special needs shelter? YES or NO (Arrive on my own)

ASSISTANCE WITH DAILY LIVING NEEDED (Check all ADLs that Apply)

1. Assistance with Daily Living: (check all that apply)

Toileting Taking Medications Feeding/Eating Walking more than 50 ft. Getting out of bed Dressing

2. Can you sleep on an adjustable back cot? YES or NO

SPECIAL NEEDS (check all that apply)

Electrical Needs	Mobility Assessment	Specialized Equipment
<input type="checkbox"/> Bi-Pap or C-Pap <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Nebulizer <input type="checkbox"/> Suction Pump <input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Oxygen: ____ of hours daily at ____ liters per minute <input type="checkbox"/> Dialysis: (#) ____ days per week	<input type="checkbox"/> I can walk -or- I use: <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair/scooter <input type="checkbox"/> Lift used to get out of bed <input type="checkbox"/> I am bedridden continuously	<input type="checkbox"/> Feeding Tube <input type="checkbox"/> IV Equipment <input type="checkbox"/> Service Animal (Canine or Miniature Pony) <input type="checkbox"/> Other _____ <input type="checkbox"/> I need a nurse or caregiver to administer medications.
Cognitive Assessment	Vision and Hearing Assessment	Special Care/Considerations
<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anxiety <input type="checkbox"/> Autism <input type="checkbox"/> Conduct disorder <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Mental health problem <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Psychiatric or personality disorder	<input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Deaf <input type="checkbox"/> Partially Blind <input type="checkbox"/> Blind	<input type="checkbox"/> Ostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Morbid obesity <input type="checkbox"/> Open wounds/Decubitus <input type="checkbox"/> Incontinence <input type="checkbox"/> Wear Adult Diapers

DIAGNOSIS

Alzheimer's and Dementia	<input type="checkbox"/> Progressive Alzheimer's disease (ALZD) <input type="checkbox"/> Psychosis (This requires full time trained caregiver) <input type="checkbox"/> Dementia (This requires full time trained caregiver)
Chronic but Stable Illness	<input type="checkbox"/> Aphasia (Difficulty communicating) <input type="checkbox"/> Cardiac Abnormalities (Controlled with medication and requiring supervision) <input type="checkbox"/> Continuous Ambulatory Peritoneal Dialysis (Stable, self care) <input type="checkbox"/> Cystic Fibrosis (Assistance with daily living) <input type="checkbox"/> Diabetes/Hyperglycemia (Requiring assistance with insulin and monitoring) <input type="checkbox"/> Dialysis (Peritoneal and Hemodialysis) (Dialysis not provided in shelter) <input type="checkbox"/> Fractured Bones (Pin care/dressing changes) <input type="checkbox"/> Neurological Deficit (Monitoring and assistance with daily living) <input type="checkbox"/> Obesity <input type="checkbox"/> Parkinson's disease (Assistance with daily living) <input type="checkbox"/> Seizures (Medication assistance)
Chronic but Stable Illness With Mobility Impairment	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cerebral Vascular Accident (Recent CVA) (Wheelchair bound) <input type="checkbox"/> Foley Catheter (Requiring Monitoring) <input type="checkbox"/> Wheelchair Bound due to Chronic Illness (Such as: ALS, CVA, Multiple Sclerosis, Muscular Dystrophy, etc.)
Electricity Dependant	<input type="checkbox"/> Electric Energized Medical Equipment (CPAP, Nebulizers, etc.) <input type="checkbox"/> Eating and Swallowing Disorders (Requiring electric equipment) <input type="checkbox"/> Sleep Apnea
Oxygen Dependant	<input type="checkbox"/> Oxygen Dependant <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) (Requiring oxygen) <input type="checkbox"/> Emphysema (Requiring oxygen)

List any other medical problems: _____

Allergies: YES or NO If yes, list: _____

ATTACH MEDICATIONS LIST (list medication name and dose)

Form Completed By: _____ Relationship: _____ Phone: _____

By submitting this form, I give my authorization for the Palm Beach County Special Needs program to release this information to other emergency response personnel, human service agencies, officials or those they deem necessary to facilitate the evaluation of this application and required activities to ensure assistance for me. Records relating to registration of disabled citizens are exempt as listed in the provisions of F.S. 119.07 (1), Public Records Law. The information contained herein will be kept confidential. I also understand that assistance will only be provided for the duration of the emergency and that alternative arrangements should be made in advance if I cannot return to my home. Should I require hospital or assisted living care, I understand that I must make these arrangements myself.

Signature of Patient / Guardian

Date