

Transportation and Special Needs Shelter Application Brevard County Emergency Evacuation Registry

HEALTHCARE AGENCY: _____ Phone: _____

Contact person: _____

FOR OFFICE USE ONLY

TRANSPORT TYPE: BUS LIFT- GATE OTHER
TRANSPORT AGENCY: SPACE COAST COASTAL PRIVATE VEHICLE
SHELTER LEVEL: GENERAL ASSISTED CARE ENHANCED CARE 24 HR VENT PATIENT

SHELTER LOCATION: _____ Patient notified of Registration: _____ Date: _____

**Please complete this form and return to: Brevard County Emergency Management
1746 Cedar Street, Rockledge, FL 32955
321-637-4088 (P) 321-633-1738 (F)**

COMPLETE ONE APPLICATION PER PERSON - THIS IS A VOLUNTARY PROGRAM
Transportation is free to all Red Cross Shelters and Special Needs Shelters.

DO YOU NEED TRANSPORTATION TO A SHELTER?

- No - (private vehicle)**
 Yes
 **Yes, TRANSPORTATION ONLY TO A RED CROSS SHELTER- I HAVE NO SPECIAL NEEDS
MEDICAL CONDITIONS**

Please check one of the following:

- I can walk to, on, and off of a bus
 I am mobile with an assistive device (walker/cane)
 I require a wheelchair lift vehicle Check: Wheelchair Electric Scooter Other _____
I Can Transfer to a seat/chair Yes No
 I am bedridden and require a stretcher and cannot transfer to a wheelchair for transport

Please check if you have a hearing impairment, vision impairment, or both:

- I am hearing impaired
 I have a vision impairment
 I have a hearing and vision impairment

*IF YOU ARE ONLY REQUESTING TRANSPORTATION TO A RED CROSS SHELTER-Please only fill out Section A
Personal Information and Section B Evacuation Information
ALL SPECIAL NEEDS CLIENTS FILL OUT ENTIRE FORM*

PERSONAL INFORMATION (Section A)

Last Name: _____ First Name: _____ MI: _____

Birth Date: _____ Sex: Male Female Height: _____ Weight: _____

Primary Language: English Spanish Other _____

Living Situation: Alone With a Caregiver Am a Caregiver

Home Address: _____ Apt./ Lot No. _____

Mailing Address (if different from above): _____

City: _____ Zip Code: _____ Phone: (____) _____

Alternate Phone: (____) _____

Residence Type: Private Home Apartment/ Condo Manufactured/ Mobile Home

If you live in an apartment or condo, do you live above the first floor? Yes/Which floor? _____ No

Name of Complex/ Subdivision/Condo or Development: _____

Name of Caretaker/ Companion: _____ Phone: _____

Contact Person **NOT** living with you in case of an emergency while evacuated:

Name: _____ Relation: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

EVACUATION INFORMATION (Section B)

My spouse will evacuate with me: Yes Name: _____ No My caretaker: Yes No

Other person(s), if any, accompanying you to the shelter: _____

PETS ARE NOT ALLOWED IN SHELTERS. MAKE EVACUATION-SHELTERING ARRANGEMENTS FOR YOUR PET NOW!

Do you have a dog(s): Yes No How many: _____ Cat(s): Yes No How many? _____

Do you have a service animal? _____ If so, type _____

******TRANSPORTATION ONLY INDIVIDUALS STOP HERE- PLEASE GO TO THE LAST PAGE AND SIGN******

PLEASE CHECK ALL MEDICAL CONDITIONS THAT APPLY

Do you require assistance with taking your medications? No Yes Type of assistance: _____

Please bring all current medications with you to the shelter

ASSISTED CARE SHELTER

(may require medical assistance)

- | | |
|--|---|
| <input type="checkbox"/> Colostomy -medical assistance needed | <input type="checkbox"/> Trach Tube - that may require suction |
| <input type="checkbox"/> Catheter - medical assistance needed | <input type="checkbox"/> Brittle Diabetic - medical assistance needed |
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Apnea Monitors |
| <input type="checkbox"/> Liquid Oxygen | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Gaseous Oxygen | <input type="checkbox"/> Peritoneal / <input type="checkbox"/> Hemo |
| <input type="checkbox"/> Rate: _____ | Frequency _____ |
| <input type="checkbox"/> Mode of Administration: _____ | <input type="checkbox"/> Sensory Loss or Impairment |
| <input type="checkbox"/> Nebulizer - more than 1 treatment a day | Assistive Device: _____ |
| <input type="checkbox"/> Cognitive Impairments (Alzheimers, etc.) | <input type="checkbox"/> Mobility Impairment |
| Type: _____ | Assistive Device: _____ |
| <input type="checkbox"/> Psychiatric Impairment | <input type="checkbox"/> G-Tube-feeding |
| Type: _____ | |
| <input type="checkbox"/> Dressing Changes Wet to Dry-medical assistance needed | Hospitalized in last 3 months for: |
| <input type="checkbox"/> Seizure Activity within the last 6 months | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Bladder & Bowel dysfunction | <input type="checkbox"/> Shock due to Internal defibrillator |
| | <input type="checkbox"/> Open Heart Surgery |

ENHANCED CARE SHELTER

(requires medical assistance)

- Imminent Death
- Hospice
- Bedsores

OTHER

- 24 Hour Ventilator Patient

PLEASE PROVIDE CONTACT INFORMATION FOR YOUR MEDICAL SUPPORT PROVIDERS, IF ANY. (EXAMPLES: HOME HEALTH AGENCY, MEDICAL EQUIPMENT PROVIDER, PRIMARY DOCTOR, ETC.)	
NAME OF AGENCY/PROVIDER	PHONE NUMBER

MEDICAL EQUIPMENT YOU USE THAT IS POWER DEPENDENT	PLEASE PROVIDE A LIST OF ALL CURRENT MEDICATIONS

POWER IS NOT GUARANTEED

THERE ARE NO BEDS, COTS OR LIFTS PROVIDED AT THE SPECIAL NEEDS SHELTERS

1. I understand that a Special Needs Shelter does not provide beds, cots, or lifts, and that I should bring my own to the extent I am capable.
2. 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.
3. I understand that assistance will only be provided for the duration of the evacuation.
4. I understand that in the event I am not able to return to my home that I will be responsible for any additional transportation or hospital expenses.
5. I understand that upon order or recommendation to evacuate my residence, if I have requested transportation, I will receive advance notice, by phone, of the date and time to expect to be picked up for transport to a shelter.
6. If I decline transportation when a transporter arrives, I understand that I may not have another opportunity to obtain this service.
7. I understand that based on this application and the data I have provided; the Office of Emergency Management will determine if any emergency evacuation assistance will be provided.
8. I understand that power is not guaranteed, due to unforeseen power fluctuations or power failures.

I certify that this information is correct to the best of my knowledge.

Applicant Signature

Date

If the person filling out this form is not the patient, please answer the following:

Name: _____ Phone: _____

Relationship/ Agency: _____

APPLICATIONS ARE TO BE RENEWED YEARLY. ANY SIGNIFICANT CHANGES TO YOUR APPLICATION, (ADDRESS CHANGE, MEDICAL CRITERIA, ETC.) NEED TO BE UPDATED WITH THE SPECIAL NEEDS COORDINATOR AS SOON AS POSSIBLE.

IF YOU REQUIRE A SPECIAL NEEDS SHELTER APPLICATION WITH LARGER PRINT, PLEASE CONTACT THE SPECIAL NEEDS COORDINATOR, (321-637-4088), AND ONE WILL BE PROVIDED TO YOU.