

2006 Special Needs Registry

Individuals are eligible to be registered with the Special Needs Registry if they are frail, elderly, medically needy, and/or disabled and are not served in or by a residential facility program. Eligible clients are required to complete and sign this application as well as the HIPAA Disclosure of Information and HIPAA Privacy Act forms before they will be placed on the registry.

Please print clearly

Social Security Number ____ - ____ - ____ Do you have Medicare? Y ____ N ____ # _____

Last Name _____ First _____ Middle Initial _____

Physical Address _____ Key _____

Mailing Address (if different) _____ City _____ Zip _____

Do you plan to evacuate to a public shelter? ----- Y ____ N ____

Do you need Monroe County to transport you to a shelter? ----- Y ____ N ____

(If you answered *no* to both of the above, you will not be registered and need only to sign the back of the form. If you answered *yes* to either or both please continue to complete the form front and back.)

If you do not have a phone, you must list a neighbor's phone number that we may use to contact you.

Nearest Mile Marker _____ Home Phone# _____ Spanish only? Y ____ N ____

Sex M ____ F ____ Date of Birth _____

If married: Name of Spouse _____ Is Spouse registered? Y ____ N ____

Residence type (**please check one**): Single family home/Duplex _____ Apartment _____ Boat _____
Condo _____ Campground/RV _____ Mobile Home _____ Other _____

Number of Pets in home: Dog _____ Cat _____ Other (type & #) _____

(NOTE: Pets of Special Needs Registry clients are eligible to, if pre-registered, accompany clients when pet-friendly sheltering is available.

However, arrangements must be made in advance of the client's pick-up)

Category storm you need transportation for 1 & 2 _____ 3 or higher _____ All _____

Are you a year round resident _____ or a seasonal resident ____ Name months you are in county _____

Can you sit up and ride in a bus or van? ----- Y ____ N ____

Do you need a wheelchair lift? ----- Y ____ N ____

Do you require an ambulance for transportation? ----- Y ____ N ____

(If yes, you will be contacted by Emergency Medical Services to assess your condition.)

Are you receiving home health care? ----- Y ____ N ____

If yes, name of agency _____ Phone number _____

If you have a required caregiver, please list their name and phone number.

Name _____ Phone number _____

Total number of people that will accompany you to a shelter? _____ (space is very limited so, please limit to one caregiver and any dependant children.)

You must give a current name and phone number of a neighbor or friend that we may use for an alternate contact: This person must live in your area & must be aware that they are listed as an alternate contact!

Name _____ Phone _____

*****TO BE FILLED OUT BY REFERRING AGENCY*****	
Agency Name:	_____
Location & Phone Number:	_____
New Client _____ Update Existing Client _____ Delete _____ (reason) _____	

Please check all that apply to your condition:

Are you dependant on any of the following:

No disabilities		<i>Catheters</i>	
Alzheimer's - *please note stage*		<i>Electricity</i>	
Ameliorating Lateral Sclerosis(ALS)		<i>I.V. Medication</i>	
Back Injury		<i>NG tube/CV infusion site/tracheostomy</i>	
Blind / Hearing or Speech Impaired		<i>Oxygen</i>	
Cerebral Palsy		<i>Respirator</i>	
Colostomy or Ileostomy <i>*specify*</i>		Dialysis - <i>*no dialysis is available on site*</i>	
Contagious Disease <i>*specify*</i>		Insulin	
Epilepsy/other seizures <i>*specify*</i>			
Fractured Bones with pin care		<i>Other *specify*</i>	
Full Paralysis			
Heart Condition		About Your Mobility:	
High blood pressure		Ambulatory(can get around on your own)	
Mental Illness <i>*specify*</i>		Ambulatory with assistance	
On special diet <i>*specify*</i>		Walker / Cane / Crutches	
Pregnant, in 7 th month or more and/or considered high risk		Wheelchair	
Severe arthritis		<i>Non-Ambulatory (bedridden)</i>	
Terminal condition		<i>Wheelchair bound</i>	
Other <i>*specify*</i>			
Is Shelter Assistance Needed For: (ADL) (Circle those that apply)			
Communications	Feeding		
Dressing changes	Medication		

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet attached and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I also grant permission to emergency personnel to enter my home following an emergency if deemed necessary by proper authorities. I understand that this registration is voluntary and hereby request registration in the Special Needs Registry (SNR). I understand that all information given will be held in strict confidence and will be used for emergencies only. I also understand that it is my responsibility to keep my information current with SNR by completing annual renewals and providing updates as my condition changes.

X _____ Date _____
Signature of Client Date of Signature

***** FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE *****		
Evac zone _____	EMS Zone _____	Date contacted _____
Transport to: Hospital _____	Nursing Home _____	Special Needs Shelter _____
HIPAA Forms Y____ N____	Transport by: EMS _____	Social Service _____

**Please return to the following: Special Needs Registry
Monroe County Transportation
1100 Simonton Street Room 1-180
Key West, FL 33040**