# ORANGE COUNTY HEALTH SERVICES DEPARTMENT
# PEOPLE WITH SPECIAL NEEDS PROGRAM
# REGISTRATION FORM

## PLEASE STOP & READ

This form is for ***NEW REGISTRATIONS ONLY.*** If you are providing an update to an existing registration, please contact Orange County 311 at (407) 836-3111.

To complete this registration form online ➡ **https://netapps.ocfl.net/psn**

## *PERSONAL INFORMATION FOR INDIVIDUAL WITH SPECIAL NEEDS*

**First Name** _____ **Middle Name** _____ **Last Name** _____

**Physical Address** _____ **Apt/Lot No.** _____ **City** _____ **State** _____ **Zip Code** _____

**Residence Type** ☐ **Single Family Home** ☐ **Mobile Home** ☐ **Multi-Family Home** ☐ **Apartment** ☐ **Other** _____

**Name of Subdivision/Condo/Mobile Home Park/Apartment Complex/Building** _____

**Primary Phone** _____ ☐ **Primary Phone is TTY/TTD** **Secondary Phone** _____ ☐ **I do not have a phone**

**Email address** _____

**Date of Birth** _____

**Gender** ☐ **Male** ☐ **Female** ☐ **Transgender** ☐ **Non-Binary** ☐ **Prefer not to answer**

**Height** _____ **Ft** _____ **In**

**Weight** _____ **lbs**

## *MAILING ADDRESS IF DIFFERENT THAN PHYSICAL ADDRESS*

☐ ***Same as physical address***

**Mailing Address** _____ **Apt/Lot No.** _____ **City** _____ **State** _____ **Zip Code** _____

## *EMERGENCY CONTACT(S) INFORMATION*

**Primary Contact**

**First Name** _____ **Last Name** _____ **Relationship** _____

**Primary Phone** _____ **Secondary Phone** _____ ☐ **Checking this box allows medical information to be shared with this contact.**

**Secondary Contact**

**First Name** _____ **Last Name** _____ **Relationship** _____

**Primary Phone** _____ **Secondary Phone** _____ ☐ **Checking this box allows medical information to be shared with this contact.**

## *CAREGIVER* (*ANY PERSON*, OFTEN A FAMILY MEMBER, WHO HELPS WITH THE ACTIVITIES OF DAILY LIVING)

**Caregiver Name** _____ **Caregiver's Phone** _____

**Do you require a 24-hour caregiver?** ☐ **Yes** ☐ **No** **Will your caregiver travel and/or stay with you?** ☐ **Yes** ☐ **No**

## *MEDICAL PROVIDERS*

**Physician's Name** _____ **Physician's Phone** _____

**Pharmacy Name** _____ **Pharmacy Phone** _____

**Home Health Care Agency Name** _____ **Home Health Care Agency Phone** _____

**Medical Equipment Provider Name** _____ **Med Equipment Provider Phone** _____

**Oxygen Provider Name** _____ **Oxygen Provider Phone** _____

## *TRANSPORTATION NEEDS*

**Transportation Required?** ☐ **Yes** ☐ **No** ☐ **Unsure**

**PLEASE CHECK ALL VEHICLE TYPES THAT CAN BE USED FOR TRANSPORTATION:**

☐ **Car can be used**
☐ **Wheelchair accessible van**
☐ **Ambulance**
☐ **Needs to be transported on a stretcher**

**Continuous oxygen is required during transport** ☐ **Yes** ☐ **No**

**Number of family members (living in your home) who will accompany you to a shelter?** ☐

## *MOBILITY NEEDS*

**Do you have mobility needs?** ☐ **Yes** ☐ **No**

☐ **Confined to Bed**
☐ **Paralyzed**
☐ **Wheelchair**
☐ **Attendant to Assist in Ambulating**

☐ **Partial Paralysis**
☐ **Complete Paralysis**

**Select all devices that are used to aid mobility**

☐ **Walker / Cane / Rollator**
☐ **Standard Wheelchair**
☐ **Motorized Wheelchair**
☐ **Motorized Scooter**

## *EQUIPMENT NEEDS*

**Are you dependent on Electrical Equipment?** ☐ **Yes** ☐ **No**

**Are you Oxygen Dependent?** ☐ **Yes** ☐ **No**

**Oxygen Type**

- ☐ **Gaseous**
- ☐ **Liquid**

**Oxygen Mode**

- ☐ **Mask**
- ☐ **Nasal Cannula**
- ☐ **Trach Collar**

**Liter Flow**

_____ **LPM**

**Frequency**

- ☐ **24 Hours**
- ☐ **Only Overnight**
- ☐ **As Needed**

**Select All Equipment Used:**

| | | | | |
|---|---|---|---|---|
| ☐ **Apnea Monitor** | ☐ **CPAP / BIPAP** | ☐ **Cardiac Monitor** | ☐ **Dialysis Catheter** | ☐ **Feeding Pump** |
| ☐ **Feeding Tube** | ☐ **Nebulizer** | ☐ **Oxygen Concentrator** | ☐ **Suction Pump** | ☐ **Ventilator** |
| ☐ **Wound Vac** | ☐ **Tracheostomy Tube** | ☐ **Hoyer Lift** | ☐ **Pulse Oximeter** | ☐ **Catheter** |
| ☐ **Medications that Require Refrigeration** | | ☐ **Other Equipment** _____ | | |

## *ADDITIONAL INFORMATION* ***Please enter any additional information that may be useful to emergency personnel.***

## *MEDICAL HISTORY*

- ☐ Alzheimer's Disease
  - ☐ Mild
  - ☐ Severe
- ☐ ALS
  - ☐ Early Stage
  - ☐ Middle Stage
  - ☐ Late Stage
- ☐ Aphasia
- ☐ Assistance with Daily Living
- ☐ Asthma
- ☐ Arthritis
- ☐ Autism
- ☐ Behavioral Health
- ☐ Blind / Low Vision / Vision Impaired
- ☐ Cancer
  - ☐ Chemotherapy
  - ☐ Radiation
  - ☐ Surgical
  - ☐ Palliative
  - ☐ Remission
  - ☐ End-stage
  - ☐ N/A
- ☐ Cardiac Type
  - ☐ Stable
  - ☐ Unstable
- ☐ Cystic Fibrosis
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Comatose
- ☐ Contagious Disease
- ☐ Cystic Fibrosis
- ☐ Deaf / Hard of Hearing
- ☐ Dementia
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
  - ☐ N/A
- ☐ Diabetes
  - ☐ Insulin Dependent
  - ☐ Non-Insulin Dependent
- ☐ Dialysis Type
  - ☐ Hemodialysis at Facility
  - ☐ Hemodialysis at Home
  - ☐ Peritoneal
  - ☐ N/A
- ☐ Dialysis Frequency
  - ☐ Daily
  - ☐ 2 times week
  - ☐ 3 times week
- ☐ Eating and Swallowing Disorder
- ☐ Edema
- ☐ Emphysema
- ☐ Fractured Bones
- ☐ Frail Elderly
- ☐ High Blood Pressure
- ☐ Hip/Knee Replacement
  - ☐ Ambulatory
  - ☐ Non-Ambulatory
  - ☐ Confined to Bed
- ☐ Incontinence
- ☐ IV Care
- ☐ Mentally / Memory Impaired
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neuromuscular Disorder
- ☐ Ostomy
- ☐ Paralysis
- ☐ Parkinson’s Disease
- ☐ Premature Birth
- ☐ Seizures
- ☐ Sleep Apnea / CPAP User
- ☐ Speech Impediment
- ☐ Stroke
- ☐ Terminal
  - ☐ Endstage
  - ☐ N/A
- ☐ Wounds / Sores / Rashes
- ☐ Other

## *SERVICE ANIMALS / PETS*

**Do you own an animal?** ☐ **Yes** ☐ **No** **What type of animal?** ☐ **Dog** ☐ **Cat** ☐ **Miniature Horse** ☐ **Other** _____

**Is this animal a service animal (e.g. a seeing-eye dog)?** ☐ **Yes** ☐ **No** **Is this animal an emotional support animal?** ☐ **Yes** ☐ **No**

**Animal's Name** _____ **Breed/Description** _____ **Weight** _____

**Is there a carrier cage available?** ☐ **Yes** ☐ **No** **Is there a leash available?** ☐ **Yes** ☐ **No** **Is there a muzzle available?** ☐ **Yes** ☐ **No**

**Do you own more than one animal?** ☐ **Yes** ☐ **No** **If yes, how many animals will accompany you to a shelter?** _____

## *Additional Information about Service Animals / Pets*

**Please list every additional animal separately along with answers to the questions asked above.**

## *ACKNOWLEDGEMENT*

**The following statements provide information on how Orange County handles Personal Health Information (PHI). They will not impact the receipt of services during time of hurricanes or disasters.**

**It is crucial to our response efforts that the information you provide be as accurate and up to date as is possible. You will be contacted periodically to verify and ensure the information provided is correct, and to make any necessary changes. Individual forms will need to be updated on an annual basis to remain active on the registry.**

**Your information will only be released to emergency response agencies for assistance during emergency and disaster situations; and emergency responders may enter your home and provide for your needs in an emergency situation.**

**Expenses associated for transport or admission to a hospital while in a shelter setting will be the client's responsibility.**

**This form was completed by:**

☐ **Special Needs Client:** **Client Signature** _____ **Date** _____

☐ **Family Member:** **Name** _____ **Phone No.** _____

☐ **Case / Social Worker:** **Name** _____ **Phone No.** _____

☐ **Healthcare Proxy:** **Name** _____ **Phone No.** _____

☐ **Other:** **Name** _____ **Phone No.** _____

**Return Completed Forms to:**
**Orange Co Special Needs Program**
**4654 35th Street**
**Orlando, FL 32811**
**FAX: (407) 836-2838**