ORANGE COUNTY HEALTH SERVICES DEPARTMENT
FLORIDA SPECIAL NEEDS FORM

PLEASE PRINT

Personal Information for Individual with Need

First Name ____________ Middle Initial______ Last Name ____________ Email: ____________

Primary Phone ( ) ____________ Ext.________ ⬭Primary Phone is TTY/TTD Date of Birth:____________

Secondary Phone ( ) ____________ Ext.________ Height: ________ Weight: ________

⬭ I Do Not Have A Phone Primary Language ____________ Gender: ⬭M ⬭F Eye Color:________

Physical Address

Home Address ____________ Apt/Lot No. ______ City ____________ State ________ Zip +4________

Residence Type: ⬭ Single Family Home ⬭ Mobile Home ⬭ Multi-Family Home ⬭ Apartment Bldg. ⬭Other____________

County: ____________ Municipality:____________

Mailing Address (Please enter if Different than your Physical Address) ⬭ Same as Physical Address

Mailing Address ____________ Apt/Lot No. ______ City ____________ State ________ Zip +4________

Personal Information for Emergency Contact:

Primary Contact

First Name ____________ Middle Initial______ Last Name ____________ Email: ____________

Address ____________ Apt/Lot No. ______ City ____________ State ________ Zip +4________

Primary Phone ( ) ____________ Ext.________ Relationship:____________ ☐ Checking this box allows medical information to be shared with this contact.

Secondary Phone ( ) ____________ Ext.________

Secondary Contact (Please enter an out-of-area contact)

First Name ____________ Middle Initial______ Last Name ____________ Email: ____________

Address ____________ Apt/Lot No. ______ City ____________ State ________ Zip +4________

Primary Phone ( ) ____________ Ext.________ Relationship:____________ ☐ Checking this box allows medical information to be shared with this contact.

Secondary Phone ( ) ____________ Ext.________

Additional Contact Information

Physician's Name____________________ Physician's Phone: ____________________

Home Health Care Agency Information____________________ Home Health Care Agency Phone: ____________________

Caregiver Name:____________________ Caregiver's Phone:____________________

Pharmacy Name____________________ Pharmacy Phone: ____________________

Evacuation Assistance Information: (Select All That Apply)

- ⬭ Blind/Low Vision
- ⬭ Deaf/Hard of Hearing
- ⬭ Behavioral Health Issues
- ⬭ Contagious Disease
- ⬭ Frail Elderly
- ⬭ Speech Impediment
- ⬭ Physical Disability (Please Explain) [ ]
- ⬭ Bedridden
- ⬭ Mentally/Memory Impaired
- ⬭ Dementia/Alzheimer's Indicate: Mild, Moderate or Severe ____________________

  Full time caregiver must be present at all times during stay at shelter.
- ⬭ Dialysis (Please indicate Hemodialysis at Facility, Hemodialysis at Home or Peritoneal) ____________________
- ⬭ Requires constant skilled nursing care *(e.g. Open Wounds)*
- ⬭ Assistance with medications
- ⬭ Assistance needed with Insulin

- ⬭ Requires Refrigerated Medications
- ⬭ Medications (Addtl Space in Comments) [ ]
- ⬭ Autism
- ⬭ Seizures
- ⬭ Special Dietary Needs/Restrictions [(Please Explain)]
- ⬭ Other reasons for needing assistance [(Please explain)]

Transportation Needs:

If transporation assistance is required, please check all vehicle types that can be used for transporation.

- ⬭ Car
- ⬭ Bus
- ⬭ Wheelchair Van
- ⬭ Ambulance

Communication Needs:

- ⬭ Does not have a radio
- ⬭ Does not have a television
- ⬭ Does not have a phone, TTY or VRI
- ⬭ Does not have Internet access
- ⬭ How do your receive emergency notifications? (Specify)

Has difficulty walking and requires:

- ⬭ Walker / Cane
- ⬭ Standard Wheelchair
- ⬭ Motorized Wheelchair
- ⬭ Motorized Scooter
- ⬭ Attendant to assist in ambulating
- ⬭ Requires Stretcher Transportation
- ⬭ Hoyer Lift

Oxygen Dependent:

Check all that apply and supply detailed information (O2 Type, Liters Flow)

- ⬭ 24 Hour ____________________
- ⬭ Only Overnight ____________________
- ⬭ Nebulizer ____________________
- ⬭ CPAP ____________________
- ⬭ Other ____________________

Oxygen Co Name____________________

Oxygen Co Phone____________________

Requires medical equipment that is not easily transportable:

- ⬭ Ventilator
- ⬭ Suction Machine
- ⬭ Catheters
- ⬭ Feeding Tube
- ⬭ Oxygen Concentrator
- ⬭ Other (Please specify)

Required Assistance

1) Are ALL of the support needs resulting in the need for evacuation assistance temporary? (Example: The individual is bedridden due to pregnancy difficulties, but is expected to be fully recovered after the baby is delivered.
◯ Yes ◯ No, the condition(s) are expected to be permanent.

Please provide an estimated date when the condition will be resolved. Month___________ Year_________

2) Is the person in need a seasonal resident? ◯ Yes ◯ No
The person in need is a seasonal resident from (Month) _____________ to (Month) ______________.

3) Does the person in need require evacuation assistance 24 hours /day? ◯ Yes ◯ No
The person in need requires evacuation assistance from ____________am/pm to _______________am/pm.

4) Does the person in need have a 24 hour caregiver? ◯ Yes ◯ No
Will the caregiver travel and/or stay with you? ◯ Yes ◯ No

Service Animals / Pets

Do you own an animal? ◯ Yes ◯ No What type of animal? ◯ Dog ◯ Cat ◯ Minature Horse ◯ Other____________________

Is this animal a service animal (eg. a seeing eye dog)? ◯ 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

Additional Comments / Information

Please enter any additional information that may be useful for our emergency personnel to evacuate this person.

Client's Signature

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.

Floridians are encouraged to prepare for all types of emergencies. Building an individual or family emergency plan is the first step. During an emergency, the government and other agencies may not be able to meet your needs. You should be prepared to take care of yourself and loved ones for a minimum of 72 hours. Those individuals with a special need are encouraged to identify an emergency support network and to build a disaster supply kit. For more information on planning visit www.FLGetAPlan.com to build your individual or family emergency plan.

Orange County Statement:
I certify this information is correct. I understand I am responsible for all expenses associated with transportation and admittance to the hospital, if needed. I hereby grant permission to Orange County for the release of this information to emergency response agencies. I understand that by signing this form, I grant emergency responders permission to enter my home and provide for my needs in an emergency.

Signature ______________________ Date ________

Case Manager Signature if Completing for Client ______________________ Date ________

Return Completed Forms to:
Orange Co Special Needs Program
2002-A E. Michigan Street
Orlando, FL 32806 FAX: (407) 836-2838