

OSCEOLA COUNTY SPECIAL NEEDS SHELTER APPLICATION

There are several shelter options that will be used in the event of an emergency:

1) **REGULAR SHELTERS** are for residents who are able to perform normal activities of daily living and can manage their own medical care.
THERE IS NO NEED TO APPLY FOR SPACE IN A REGULAR SHELTER.

2) **SPECIAL NEEDS SHELTER**

YOU MAY BE ELIGIBLE FOR A SPECIAL NEEDS SHELTER IF YOU REQUIRE ASSISTANCE WITH ACTIVITIES OF DAILY LIVING. SOME EXAMPLES:

- ✓ YOU NEED SOME ASSISTANCE WITH THE ADMINISTRATION OF MEDICINES
- ✓ YOU ARE OXYGEN OR ARE ELECTRICITY DEPENDANT
- ✓ YOU SUFFER FROM EMPHYSEMA, PARTIAL PARALYSIS, HEART PROBLEMS, PARKINSON'S DISEASE, DEMENTIA OR INCONTINENCE.

IT IS REQUIRED TO APPLY FOR A SPECIAL NEEDS SHELTER ANNUALLY.

3) **HOSPITAL ADMITTANCE**

If you suffer from an unstable medical condition or are receiving on-going treatment, then a Special Needs Shelter MAY NOT meet your needs. YOU MUST TALK TO YOUR DOCTOR NOW ABOUT BEING ADMITTED TO A HOSPITAL DURING AN EMERGENCY. THIS INCLUDES LATE TERM PREGNANCY AND OTHER UNSTABLE CONDITIONS.

NOTE:

- **SPECIAL NEEDS SHELTERS ARE FOR CLIENTS AND THEIR DESIGNATED CARE GIVER ONLY. EFFORTS WILL BE MADE TO ACCOMMODATE REGULAR FAMILY MEMBERS IN A REGULAR SHELTER.**
- **APPLICATION DOES NOT AUTOMATICALLY GUARANTEE ASSIGNMENT; THE ASSIGNED TRIAGE MEDICAL ADVISOR AT THE SHELTER WILL MAKE THE FINAL DETERMINATION.**
- **CLIENTS MUST PROVIDE THEIR OWN MEDICATION, MEDICAL EQUIPMENT AND AT LEAST 24 HOURS OF OXYGEN. CURRENT MEDICAL RECORDS WILL BE REQUIRED.**
- **PETS ARE NOT ALLOWED IN A SPECIAL NEEDS SHELTER. IF YOU ARE UNABLE TO MAKE PRIVATE ARRANGEMENTS FOR YOUR PETS, LET US KNOW. TRANSPORTATION WILL BE PROVIDED TO TAKE THEM TO A PET SHELTER. YOU WILL NEED TO HAVE YOUR ANIMAL'S VACCINATION RECORDS AVAILABLE.**
- **ONCE YOU HAVE BEEN ACCEPTED, YOU WILL BE PROVIDED WITH A LIST OF THE ITEMS YOU NEED TO BRING TO THE SPECIAL NEEDS SHELTER.**

Please complete the attached forms and return immediately.

PLEASE RETURN YOUR SPECIAL NEEDS REGISTRATION FORM TO:

OSCEOLA COUNTY HEALTH DEPARTMENT
ATTENTION: SPECIAL NEEDS REGISTRATION
1875 BOGGY CREEK ROAD
KISSIMMEE, FL 34744
(407) 343-2133

**OSCEOLA COUNTY SPECIAL NEEDS SHELTER APPLICATION
2012**

DATE: _____

PLEASE COMPLETE ALL AREAS ON BOTH PAGES (PRINT)

LAST NAME:		FIRST NAME:		MI:
STREET ADDRESS:			APT/LOT #	
CITY:		ZIP:	PHONE:	
COMMUNITY/SUBDIVISION NAME:		MALE <input type="checkbox"/>	IS THIS A MOBILE HOME?	
		FEMALE <input type="checkbox"/>	YES ___ NO ___	
DATE OF BIRTH:	AGE:	HEIGHT:	WEIGHT IN LBS:	
LIVING SITUATION: (CHECK ONE) ___ ALONE ___ SPOUSE ___ CHILDREN ___ PARENTS ___ OTHERS				

NOT LIVING WITH YOU - NAME OF FAMILY OR FRIEND IN CASE OF EMERGENCY	
NAME: _____	PHONE: _____
RELATIONSHIP TO YOU? _____	

SPEAK ENGLISH: YES ___ NO ___ IF NO WHAT LANGUAGE? _____
--

WILL YOU BE ACCOMPANIED TO THE SHELTER BY A CAREGIVER? YES ___ NO ___	
CAREGIVER'S NAME: _____	PHONE: _____
RELATIONSHIP: _____	AGE: _____ MALE: ___ FEMALE: ___

DO YOU HAVE TRANSPORTATION TO THE SPECIAL NEEDS SHELTER? YES ___ NO ___
IF TRANSPORTATION IS NEEDED, CAN YOU HANDLE STEPS ON A BUS? YES ___ NO ___
IF NOT, WILL YOU NEED A WHEELCHAIR LIFT? YES ___ NO ___

HOME HEALTH AGENCY: _____	PHONE: _____
PHYSICIAN: _____	PHONE: _____
OXYGEN & MED. SUPPLY COMPANY: _____	PHONE: _____
PHARMACY _____	PHONE: _____

**OSCEOLA COUNTY SPECIAL NEEDS SHELTER APPLICATION
2012**

NAME: _____

DATE: _____

PLEASE TELL US ABOUT YOUR MEDICAL CONDITION - CHECK ALL THAT APPLY:

<input type="checkbox"/> OXYGEN DEPENDENT
<input type="checkbox"/> PORTABLE TANK
<input type="checkbox"/> NEBULIZER
<input type="checkbox"/> CPAP MACHINE
<input type="checkbox"/> ASTHMA
<input type="checkbox"/> OTHER _____
<input type="checkbox"/> CARDIAC CONDITION
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> PACEMAKER
<input type="checkbox"/> HISTORY OF STROKE
<input type="checkbox"/> PARTIAL PARALYSIS
<input type="checkbox"/> DETAILS _____
<input type="checkbox"/> ANXIETY/DEPRESSION

<input type="checkbox"/> DIABETIC
<input type="checkbox"/> INSULIN DEPENDENT
WALKING
MOBILE YES <input type="checkbox"/> NO <input type="checkbox"/>
<input type="checkbox"/> FALLS
<input type="checkbox"/> CANE
<input type="checkbox"/> WALKER
<input type="checkbox"/> WHEELCHAIR/SCOOTER
<input type="checkbox"/> OTHER _____
<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> CANCER
<input type="checkbox"/> CURRENT TX. _____
<input type="checkbox"/> ALZHEIMER/DEMENTIA

<input type="checkbox"/> PARKINSON'S
<input type="checkbox"/> SEIZURES _____
<input type="checkbox"/> DIALYSIS
<input type="checkbox"/> DAYS OF TX: M T W Th F S
AGENCY NAME:
<input type="checkbox"/> ANEMIA
<input type="checkbox"/> HEARING IMPAIRED
<input type="checkbox"/> LIMITED VISION
<input type="checkbox"/> BLIND
<input type="checkbox"/> HELP NEEDED WITH MEDS?
<input type="checkbox"/> INCONTINENCE
<input type="checkbox"/> INDWELLING CATHETER
<input type="checkbox"/> COLOSTOMY OR ILEOSTOMY

DETAILS ON MEDICAL CONDITION: _____
LIST ALLERGIES: _____
SPECIAL DIETARY NEEDS: _____ LIST FOOD ALLERGIES: _____

CURRENT MEDICATIONS		
1) _____	4) _____	7) _____
2) _____	5) _____	8) _____
3) _____	6) _____	9) _____

PETS YES ___ NO ___ # OF CATS ___ # OF DOGS ___ OTHER _____

I AGREE THAT MY NAME MAY BE ADDED TO THE SPECIAL NEEDS SHELTER LIST. I GIVE OSCEOLA COUNTY EMERGENCY MANAGEMENT AUTHORITY TO SHARE THIS INFORMATION WITH OTHER AGENCIES IN THE EVENT OF AN EMERGENCY EVACUATION. I UNDERSTAND THAT BY SIGNING THIS FORM, I GRANT EMERGENCY RESPONDERS PERMISSION TO ENTER MY HOME AT THE TIME OF AN EMERGENCY. I UNDERSTAND THE LIMITATION ON THE SERVICES AND LEVEL OF CARE AVAILABLE.

SIGNED: _____

DATE: _____

NOTE: THIS FORM MUST BE SIGNED BY THE SPECIAL NEEDS CLIENT OR AUTHORIZED AGENT!

IF AUTHORIZED AGENT: NAME: _____

PHONE: _____

RELATIONSHIP TO CLIENT: _____

PERSON COMPLETING FORM (PRINT): _____

EVACUATION CHECKLIST FOR SPECIAL NEEDS EVACUEES

Listed below are actions you should take **BEFORE** evacuations. You and your caregiver **MUST** be ready before your county evacuation transportation vehicle arrives. Special Needs evacuations need to be completed prior to road congestion. Even if the sun is shining, the storm is on its way!! Osceola County Emergency Management, Osceola County Health Department and/or Osceola County Council on Aging will call to give you an estimated time of your transportation pick-up.

HERE ARE SOME THINGS YOU SHOULD DO BEFORE BEING PICKED UP:

WHEN EVACUATING:

1. Pack a bag and be ready to go with:
 - Medications for 3 weeks, list of medications, Pharmacy name & number, Doctors' name & number, your walker, wheelchair and other medical equipment
 - If oxygen dependent, bring all equipment. Emergency oxygen will be provided.
 - Clean clothes for three days
 - Extra eye glasses & flashlight
 - Blankets and pillows, sheet if desired for cot
 - Personal hygiene items, towel & wash cloth
 - House keys and car keys
 - Personal phone book or list of important numbers
 - Important papers, including identification, sealed in zip-lock bags
 - Folding chair, lawn chair or cot
 - Reading materials
 - Non-perishable snack items, bottle of water while shelter becomes fully operational
 - Non-perishable food items if you require a special diet
 - Medical orders including "Do Not Resuscitate" order, if applicable.
2. Call caretaker and family members including those out of state, to inform them of your evacuation plans.
3. It is important to turn off electricity, water and gas if possible. Be sure to follow turn off instructions given by your utility company.

WHEN STORM IS APPROACHING:

1. Take care of all medical needs such as dialysis when you hear a storm is approaching.