Osceola County Special Needs Shelter Application

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

1) Regular Shelters
This type of shelter is 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 medical care. Some examples:

- You need some assistance with the administration of medicines
- You are oxygen or electricity dependent
- You suffer from incontinence, partial paralysis, heart problems, Parkinson’s Disease, dementia, or require dialysis

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 are encouraged to talk to your doctor now about being admitted to a hospital during an emergency.

Please Note:
- It is required to apply for a special needs shelter annually.
- Special needs shelters are for clients and their designated care giver.
- Final special needs shelter admittance will be made upon arrival at the shelter based on your current medical condition.
- Please bring your medication, necessary medical equipment, and at least 24 hours of oxygen. Current medical information will be required.
- Animals are not allowed in a special needs shelter, with the exception of registered service animals. If you are unable to make private arrangements for your pets, please let us know. Transportation will be provided to take your pet to be sheltered by Osceola County Animal Services. Please have your animal’s vaccination records available.

Please Complete and Return Your Special Needs Registration Form To:
Osceola County Emergency Management
Attention: Special Needs Registration
2586 Partin Settlement Road
Kissimmee, FL 34744
Fax: (407) 742-9022

Questions: email specialneeds@osceola.org or call (407) 742-9001

**OSCEOLA COUNTY SPECIAL NEEDS SHELTER APPLICATION**

**2018**

**PLEASE COMPLETE ALL AREAS ON BOTH PAGES (PRINT)**

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<th>LAST NAME</th>
<th>FIRST NAME</th>
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<th>STREET ADDRESS</th>
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<tr>
<th>CITY</th>
<th>ZIP</th>
<th>HOME PHONE</th>
<th>CELL PHONE</th>
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<tr>
<th>COMMUNITY/SUBDIVISION NAME</th>
<th>MALE</th>
<th>FEMALE</th>
<th>IS THIS A MOBILE HOME?</th>
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<td>YES [ ] NO [ ]</td>
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<th>DATE OF BIRTH</th>
<th>AGE</th>
<th>HEIGHT</th>
<th>WEIGHT IN LBS</th>
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LIVING SITUATION: (CHECK ONE) __ALONE__ __SPOUSE__ __CHILDREN__ __PARENTS__ __OTHERS__

OTHERS IN YOUR HOUSEHOLD REGISTERED FOR THE SPECIAL NEEDS SHELTER: YES [ ] NO [ ]

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<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>RELATIONSHIP</th>
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NOT LIVING WITH YOU - NAME OF FAMILY OR FRIEND IN CASE OF EMERGENCY

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<th>NAME</th>
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RELATIONSHIP TO YOU: ______________________

SPEAK ENGLISH: YES [ ] NO [ ] IF NO WHAT LANGUAGE? ______________________

WILL YOU BE ACCOMPANIED TO THE SHELTER BY A CAREGIVER? YES [ ] NO [ ]

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<th>CAREGIVER’S NAME</th>
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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 [ ]

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<th>HOME HEALTH AGENCY</th>
<th>PHONE</th>
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<th>PHYSICIAN</th>
<th>PHONE</th>
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<thead>
<tr>
<th>OXYGEN &amp; MED. SUPPLY COMPANY</th>
<th>PHONE</th>
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<th>PHARMACY</th>
<th>PHONE</th>
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PLEASE TELL US ABOUT YOUR MEDICAL CONDITION - CHECK ALL THAT APPLY:

- OXYGEN DEPENDENT
- PORTABLE TANK
- NEBULIZER
- CPAP MACHINE
- ASTHMA
- OTHER ____________
- CARDIAC CONDITION
- RECENT SURGERY
- HIGH BLOOD PRESSURE
- PACEMAKER
- HISTORY OF STROKE
- PARTIAL PARALYSIS
- DETAILS _______________
- ANXIETY/DEPRESSION
- DIABETIC
- INSULIN DEPENDENT
- WALKING
- MOBILE YES  NO
- FALLS
- CANE
- WALKER
- WHEELCHAIR
- SCOOTER
- OTHER _______________
- ARTHRITIS
- CANCER
- CURRENT TX. ________
- ALZHEIMER/DEMENTIA
- PARKINSON'S
- SEIZURES ____________
- DIALYSIS
- DAYS OF TX: M T W Th F S
- AGENCY NAME: 
- ANEMIA
- HEARING IMPAIRED
- DEAF
- LIMITED VISION
- BLIND
- HELP NEEDED WITH MEDS?
- INCONTINENCE
- INDWELLING CATHETER
- COLOSTOMY OR ILEOSTOMY

DETAILS ON MEDICAL CONDITION: ______________________________________________________

LIST ALLERGIES: ________________________________________________________________

SYMPTOMS IF EXPOSED TO ALLERGY: _________________________________________________

SPECIAL DIETARY NEEDS: _________________________ LIST FOOD ALLERGIES: _______________

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<th>CURRENT MEDICATIONS</th>
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<td>3) ________________</td>
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PETS  YES  NO  # OF CATS  # OF DOGS  # OF SERVICE ANIMALS  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): 
Osceola County Special Needs Shelter 2586 Partin Settlement Road Kissimmee, FL 34744 Fax: 407-742-9022
Special Needs Shelter Evacuation Checklist

Listed below are steps you should take to be prepared for an evacuation:

1. Pack a bag and be ready to go with:
   - ☐ One week supply of medication
   - ☐ List of current medications with pharmacy name and telephone number
   - ☐ Medical Provider’s name and telephone number
   - ☐ Required medical equipment including a walker, wheelchair, or cane
   - ☐ If oxygen dependent, bring necessary equipment including portable tanks
   - ☐ Clean clothes for three days
   - ☐ Eye glasses, contacts, hearing aids, and/or dentures
   - ☐ Flashlight with batteries
   - ☐ Blankets and pillows for cot
   - ☐ Personal hygiene items to include towel & wash cloth
   - ☐ House keys and car keys
   - ☐ Personal phone book or list of important numbers
   - ☐ Important papers, including identification and insurance, in zip-lock bags
   - ☐ Folding chair or lawn chair
   - ☐ Reading materials
   - ☐ Non-perishable snack items and bottled water
   - ☐ 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 secure your home. Be sure any household appliances that could possibly cause a hazard are off prior to your departure.

4. If possible, take care of all medical needs prior to evacuation

Please Note:

- If you require evacuation transportation assistance, you and your caregiver MUST be ready prior to transportation arrival.

- Osceola County Emergency Management, Florida Department of Health in Osceola County and/or Osceola County Council on Aging may call to give you an estimated time of your transportation pick-up.