



**LEE COUNTY EMERGENCY MANAGEMENT
SPECIAL MEDICAL NEEDS PROGRAM**
2675 ORTIZ AVENUE, FORT MYERS, FL 33905
FOR INFORMATION CALL 239-533-0640 / FAX 239-477-3636



Applications will NOT be processed when Lee County is in the 7-day hurricane cone.

Fields marked with an asterisk (*) are required. Incomplete applications will be returned for completion.

PERSONAL INFORMATION

First Name* _____ MI _____ Last Name* _____ Suffix _____
 Date of Birth* _____ Gender _____ Height (Ft) _____ Height (In) _____ Weight _____
 Primary Language* _____ Veteran: **Y** or **N** Primary Phone* _____ TTY Device: **Y** or **N**
 Secondary Phone _____ Email* _____ Preferred Contact Method: _____

PHYSICAL ADDRESS

Address* _____ Apt/Unit _____ City* _____ State: FL
 Zip Code* _____ Subdivision / Community _____ Gate Code _____
 Stairs*: **Y** or **N** # of Flights _____
 Living with Spouse: **Y** or **N**
 Utility Company*: **LCEC** or **FPL** or **Other**: _____

| | |
|---|---|
| <p>Residence Type (circle one)*:</p> <p align="center">Single Detached Home Duplex Apartment/Condominium Mobile/Manufactured Home Boat</p> | <p>Living Situation (circle one)*:</p> <p align="center">I live alone I live with relatives I live with a caregiver Other: _____</p> |
|---|---|

MAILING ADDRESS*

Same as above Address _____ Apt/Unit/PO Box _____
 City _____ State _____ Zip Code _____

CAREGIVER INFORMATION If you have a caregiver, you must provide their first & last name and primary phone.

Do you require a 24-hour caregiver?* **Y** or **N**
 Will your caregiver stay with you at the shelter?* **Y** or **N**
 First Name _____ Last Name _____ Caregiver Email _____
 Caregiver Primary Phone _____ Caregiver Secondary Phone _____

PRIMARY EMERGENCY CONTACT - LOCAL PREFERRED

First Name* _____ Last Name* _____ Relationship* _____
 Address* _____ Apt/Unit _____ City* _____ State* _____
 Zip Code* _____ Primary Phone* _____ Secondary Phone _____
 Email _____



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SECONDARY EMERGENCY CONTACT

First Name _____ Last Name _____ Relationship _____
 Address _____ Apt/Unit _____ City _____
 State: _____ Zip Code: _____ Primary Phone _____
 Secondary Phone _____ Email _____

PROVIDER INFORMATION

Primary Care Physician _____ Primary Care Phone _____
 HHA Provider _____ HHA Contact Name _____ HHA Phone _____

I have a Do Not Resuscitate (DNR). **Y** or **N**

If you do have a DNR, your original document signed by your doctor **MUST** be with you at the shelter.

SPECIAL CARE ASSESSMENT

Please check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Blind/Low Vision | <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> C Diff |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Wounds | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Decubitus Ulcers | <input type="checkbox"/> Recent Hospital Discharge |
| <input type="checkbox"/> Insulin Dependent | <input type="checkbox"/> Frail/Elderly | <input type="checkbox"/> Terminally Ill |

Hemodialysis: **At Home** or **At Facility**
 Hemodialysis Frequency _____
 Dialysis Facility Name _____
 Dialysis Facility Phone Number _____

Other Special Care:

COGNITIVE ASSESSMENT

Circle the stage level of all that you check: **(1) mild/early, (2) moderate, or (3) late/advanced**

- | | | |
|--|---|---|
| <input type="checkbox"/> Obsessive Compulsive Disorder 1, 2 or 3 | <input type="checkbox"/> Dementia 1, 2 or 3 | <input type="checkbox"/> Psychiatric Disorder 1, 2 or 3 |
| <input type="checkbox"/> Developmental Impairment 1, 2 or 3 | <input type="checkbox"/> Bipolar Disorder 1, 2 or 3 | <input type="checkbox"/> Conduct Disorder 1, 2 or 3 |
| <input type="checkbox"/> Causes harm to self/others 1, 2 or 3 | <input type="checkbox"/> Anxiety 1, 2 or 3 | <input type="checkbox"/> Parkinson's 1, 2 or 3 |
| <input type="checkbox"/> Alzheimer's Disease 1, 2 or 3 | <input type="checkbox"/> Depression 1, 2 or 3 | |
| <input type="checkbox"/> Autism Spectrum | Autism Level _____ | |

Other Cognitive Issues / Stage Levels:



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MOBILITY ASSESSMENT

- | | |
|---|---|
| <input type="checkbox"/> I can walk on my own | <input type="checkbox"/> I need a Hoyer lift |
| <input type="checkbox"/> I need an attendant to help with walking | <input type="checkbox"/> Amputee |
| <input type="checkbox"/> I can stand and walk with a cane | <input type="checkbox"/> Paraplegic |
| <input type="checkbox"/> I use a walker/wheeled seat walker | <input type="checkbox"/> Quadriplegic |
| <input type="checkbox"/> I am bed-bound | <input type="checkbox"/> White Cane |
| <input type="checkbox"/> I use a standard wheelchair | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> I use a motorized wheelchair/scooter | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> I require a stretcher transport | <input type="checkbox"/> Muscular Dystrophy (MD) |
| <input type="checkbox"/> I weigh over 300 pounds | <input type="checkbox"/> ALS (Lou Gehrig's Disease) |

Other Mobility Issues:

WHAT HELP DO YOU REQUIRE?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Dressing | <input type="checkbox"/> External or Self Catheter |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Bowel/Bladder Incontinence |
| <input type="checkbox"/> Getting In/Out of Bed | <input type="checkbox"/> Feeding | <input type="checkbox"/> Assistance w/ Medications |
| <input type="checkbox"/> Communicating | <input type="checkbox"/> Wound Care | |
| <input type="checkbox"/> Bathing/Showering | <input type="checkbox"/> Ostomy | |

Other Help Requirements:

ELECTRICITY ASSESSMENT

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Ventilator | <input type="checkbox"/> Oxygen Concentrator | <input type="checkbox"/> Refrigerated Medication |
| <input type="checkbox"/> Nebulizer | <input type="checkbox"/> Cardiac Monitor | <input type="checkbox"/> Apnea Monitor |
| <input type="checkbox"/> Feeding Pump | | |

Other Electrical Dependencies:

OXYGEN ASSESSMENT

Oxygen Type (circle one): **24 Hours** or **Overnight** or **Other:** _____
 Liters Flow (L/min) _____ Oxygen Company _____
 Oxygen Company Phone _____



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ADDITIONAL MEDICAL INFORMATION

I have allergies. **Y** or **N** If yes, list all and note if you have a severe reaction below.
I take prescription medication(s). **Y** or **N** If yes, list below.

TRANSPORTATION TO SHELTER

- I will provide my own transportation.
- I need transportation – paratransit bus.
- I am bed-bound and require stretcher transport.
- I am bed-bound but have a wheelchair to use for transportation.

PET SHELTERING NEEDS

| Service Animal | Name | Type | Breed | Weight | Carrier | Leash | Muzzle |
|----------------|------|------|-------|--------|---------|--------|--------|
| Y or N | | | | | Y or N | Y or N | Y or N |
| Y or N | | | | | Y or N | Y or N | Y or N |
| Y or N | | | | | Y or N | Y or N | Y or N |

REPRESENTATIVE/REGISTRANT INFORMATION The information for who completed this form.

Representative's Name* _____ Representative's Contact Information* _____

Representative's Relationship to Registrant (circle one)* :

Self Spouse/Partner Neighbor/Friend Case Worker Home Health Care Aid Other _____

By checking this box, I understand this registration is voluntary and do hereby request to be registered in the Lee County Special Medical Needs Program. The information contained herein is true and correct to the best of my knowledge. I understand there are limitations to the services and levels of care that are available. I hereby grant permission to medical providers, transportation agencies, and others, to provide care and respond to my needs, and for the disclosure of any information necessary to do so. I also grant permission to emergency response agencies to enter my residence for the purpose of emergency search and rescue, and authorize the release of information necessary for these agencies to perform these services. In an effort to ensure the safety of all shelter residents, a background screening will be ran on all people evacuating to the Special Medical Needs Shelter, including the caregiver. Records of individuals registered for the Special Medical Needs Program are exempt from the provisions of S.119.07(1), Florida Statutes.

It is not necessary to fill out a new application every year. Please call (239) 533-0640 once a year by May 1st to update your application. Thank you!

Applicant Name _____ **4**