Flagler County Emergency Services
PSN Registration
1769 East Moody Blvd #3
Bunnell, FL 32110

FOLD HERE

PERSON WITH SPECIAL NEEDS APPLICATION

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FLAGLER COUNTY EMERGENCY SERVICES
PSN REGISTRATION
1769 East Moody Blvd #3
Bunnell, FL 32110

Person with Special Needs Criteria

The Person with Special Needs shelter or any evacuation shelter **will only be available as a last resort for people who have no other place to go**. These shelters cannot offer the same level of care that is available in a hospital or other health care facility. If you need to evacuate, seek shelter with relatives, friends, or in hotels/motels.

The PSN shelter is a temporary facility capable of providing **limited** medical care to individuals who require services of a caregiver or home health care provider in their everyday activities due to medical conditions and/or disabilities.

Supplies at the shelter are limited and it may be several hours before more supplies arrive. You should bring at least a 72-hour supply of all medications (in original containers), medical supplies (i.e. gauze, saline, etc.), and personal items (i.e. hygiene products, clothing, diapers, pillows, blankets, etc.) in a small travel bag to the shelter.

To submit an application for registration to PSN shelter, complete the application in its entirety and return it to: **Flagler County Department of Emergency Services, PSN Registration, 1769 East Moody Blvd #3, Bunnell, FL 32110.** When your application is received and reviewed, you will be notified about the services we will be able to provide.

All records, data, information, correspondence, and communications relating to the registration of persons with special needs are **confidential** and exempt from public records laws as stated in Florida State Statute119.07(1).

Application for Person with Special Needs Shelter

Please read the instructions and information provided before completing the form.
This form must be completed in full or it will be returned to you. Please print clearly.

Section I - Personal Information – Please Print or Type.

Date of application: ____/____/____

Last name:_____ **First name:** _____ **MI:** _____ Sex ___M ___F

Date of Birth ____/____/_____ **Last 4 digits of Social Security Number**: _____ (FOR IDENTIFICATION PURPOSES)

Type of Residence: ☐ House /Duplex ☐ Apt./Condo (What floor _____) ☐ Mobile Home/Trailer
☐ Group Home ☐ Nursing Home

Address: _____ Apt/Lot #: _____ City/Zip Code: _____

Mailing address (if different from above): _____

Telephone: Home: (___)_____ (TTY/TDD line ☐ Yes) Alternate: (___)_____ Primary Language: _____

Do you live at the above address all year round? ☐ Yes ☐ No If No, From ____ To_____

Do you live alone? ☐ Yes ☐ No If No, Name of other resident: _____

Name of Emergency Contact (not living with you): _____

Home phone: (_____)_____ Work phone: (_____)_____

Address: _____ City/State: _____ Zip: _____

Are you receiving hospice care? ☐ Yes ☐ No Agency: _____ Phone: _____ Fax: _____

Are you receiving home health care? ☐ Yes ☐ No Agency: _____ Phone: _____ Fax: _____

Primary Pharmacy:_____Phone:_____Fax:_____

Section II - Medical Information

In case of an emergency evacuation, where do you plan to go?

☐ I have made arrangements to stay with relatives, friends, a community organization, or hotel.

☐ I am unable to make other arrangements and must go to an evacuation center.

☐ I have pets (☐ Dog ☐ Cat ☐ Bird ☐ Other) Have you made arrangements for them? ☐ Yes ☐ No

***Please indicate the number of each type of pet**: ___ Dog(s) ___ Cat(s) ___ Bird(s) ___ Other

I have a caretaker or companion(s)* who will accompany me to the evacuation center. ☐ Yes ☐ No
* If your companion is also in need of assistance they should fill out a separate form.

Name(s) of caretaker or companion(s) accompanying you to shelter: _____

Do you require assistance with activities of daily living? ___ Yes ___ No

What type of assistance do you require on a daily basis? (Check all that apply)

☐ personal care (dressing/toileting) ☐ mobility (walking/transferring) ☐ taking medication

☐ guidance (blind/visual impairment) ☐ feeding

☐ skilled medical/mental health care: (☐ intermittent ☐ continuous) ☐ airway suctioning

☐ communicating: (☐ deaf ☐ nonverbal) ☐ oxygen: (☐ intermittent ☐ continuous) _____Liters/per hour

☐ wound care. If yes, what type of wound: _____

☐ I use medical equipment requiring electricity: (☐ intermittent ☐ continuous)

Specify medical equipment needing electricity: _____

List of Medical Supplies: _____

I have the following conditions: (Check all that apply)

☐ **Alzheimer's Disease:** ☐ early ☐ moderate ☐ advanced ☐ **Dementia** ☐ **Cystic Fibrosis**

☐ **Cardiac:** ☐ stable ☐ unstable ☐ **Cerebrovascular Accident (CVA)/Stroke** ☐ **Dialysis** Type:_____

☐ **Chronic Obstructive Pulmonary Disease (COPD)** ☐ **Emphysema**

☐ **Hip replacement** Date of surgery: _____ ☐ **Knee replacement** Date of surgery:_____

☐ **Neuro-muscular disorders:** ☐ early ☐ moderate ☐ advanced ☐ **Psychosis:** ☐ controlled ☐ uncontrolled

☐ **Parkinson's Disease:** ☐ early stages ☐ advanced ☐ **Seizures:** ☐ controlled ☐ uncontrolled

☐**DNR (Do Not Resuscitate) – copy of must accompany person to the shelter.**

Limitations resulting from above conditions: _____

Other Medical Conditions _____

Do you need transportation or assistance to the shelter? (Check all that apply.)

- ☐ Private transportation (I can drive myself, have someone who will drive me, will make my own arrangements.)
- ☐ Public transportation.
- ☐ I am in a wheelchair and need a lift gate vehicle.
- ☐ **I require transportation by stretcher*.**
- ☐ **I need an ambulance for transport*.** My condition requires: ☐ Basic Life Support ☐ Advanced Life Support
- ☐ I am unable to use any of the above. Reason: _____

*** Patient will be responsible for cost of ambulance.**

Patient must make applicable selection(s) for statements below.

I use: ☐ Wheelchair ☐ Walker/Cane ☐ Crutches ☐ Guide dog/Service animal ☐ None

I am bed bound: ☐ Yes ☐ No

Primary Physician: _____ **Phone**: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Name of person filling out form: _____ Telephone number: _____

Applicant Signature

I certify that this information is correct. I understand that based on this application and the data I have provided, the Office of Emergency Management will determine which emergency evacuation assistance, if any, this program may be able to provide. I understand that assistance will only be provided for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospitals or other medical facilities or transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs.

☐ **I authorize** ☐ **I do not authorize** emergency personnel to enter my home during search and rescue operations if necessary to assure my safety and welfare following a disaster.

Applicant Signature: _____ Date: _____ Witness Signature: _____ Date:_____

Do Not Write Below This Line

Zone: _____ **Reviewed by:** _____ **Date:** _____ **Record No:** _____ **FCHD**_____

PSN Shelter: _____ **Date:** _____ **Notify Only:** _____ **Date:** _____

Revised 06/25/2013