

SPECIAL NEEDS APPLICATION FORM

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WEBSITE: www.hardeecounty.net/eoc

404 WEST ORANGE STREET

WAUCHULA, FLORIDA 33873

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PLEASE PRINT CLEARLY

For convenience and comfort, citizens are encouraged to make their own evacuation and shelter plans if possible. As an alternative, the PSN program addresses the needs of people who have medical conditions or need transportation to shelters.

(FOR OFFICE USE ONLY)					
Date Received	Initials	Date Approved	Initials	Date Denied	Initials

PERSONAL INFORMATION

NAME: _____ BIRTH DATE: ____/____/____ AGE: _____

ADDRESS: _____ APT. #: _____
 Street City State Zip Code

P.O. BOX: _____ LIVE ALONE: YES NO
 City State Zip Code (Please Check)

NAME OF COMPLEX: _____ HOW MANY STORY(S): _____

PHONE #: _____ WEIGHT: _____ lbs HEIGHT: _____

LANGUAGE: _____ ENGLISH ONLY _____ SPANISH ONLY _____ BI-LINGUAL

TYPE OF HOME: _____ SINGLE FAMILY _____ MOBILE HOME _____ APARTMENT

CONSTRUCTION: _____ WOOD FRAME _____ BLOCK _____ NOT SURE

LOCAL EMERGENCY CONTACT PERSON: _____ PHONE #: _____

PRIMARY DOCTOR'S NAME: _____ PHONE #: _____

NAME OF HOME HEALTH / HOSPICE / NURSING AGENCY: _____

NAME OF EQUIPMENT & SUPPLY PROVIDER: _____

TRANSPORTATION NEEDS

WILL YOU NEED EVACUATION TRANSPORTATION: YES NO (Please Check)

IF MARKED "YES" ABOVE... WHAT KIND OF TRANSPORTATION DO YOU NEED? _____ AMBULANCE
 _____ STANDARD VEHICLE _____ STRETCHER VEHICLE _____ WHEELCHAIR VEHICLE

PLEASE CHECK THE TYPE OF TRANSPORTATION ASSISTANCE YOU REQUIRE:
 _____ NO TRANSPORTATION IS NEEDED _____ CAN YOU LAY FLAT
 _____ TRANSPORTATION TO SPECIAL NEEDS SHELTER _____ NEED ASSISTANCE ENTERING /
 _____ TRANSPORTATION TO NURSING HOME / HOSPITAL _____ EXITING A VEHICLE

MEDICAL HISTORY (Please Check All That Applies)

_____ SKIN INFECTIONS	_____ HEART CONDITION (stable/CHF)	_____ OSTOMY
_____ DEMENTIA (early)	_____ HIGH BLOOD PRESSURE	(type:) _____
_____ ARTHRITIS	_____ SKIN DISEASE	_____ SEIZURES (controlled)
_____ ASTHMA	_____ DIABETES	_____ KIDNEY DISEASE (stable)
_____ BRONCHITIS	_____ EDEMA	_____ EMPHYSEMA / COPD

_____ MUSCULAR DYSTROPHY (MD)	_____ HIP / KNEE REPLACEMENT (less than 6 months)
_____ STROKE / CVA (limitations)	_____ CEREBRAL PALSY (CP)
_____ OPEN SORES	_____ APHASIA
_____ NEBULIZER	_____ OXYGEN USE,
_____ MULTIPLE SCLEROSIS (MS)	_____ L/MIN (liters per minute, number on dial)

_____ COMATOSE
_____ PARKINSON'S DISEASE (early)
_____ MEDICAL EQUIPMENT (IV, tube, feeder, indwelling catheter)
_____ SPECIAL DIET (**bring any doctor-prescribed food items with you when you evacuate**)

_____ DEMENTIA (moderate to late)
_____ PARKINSON'S DISEASE (advanced)

_____ PSYCHOSIS (uncontrolled)
_____ UNSTABLE HEART CONDITION
_____ SEIZURES (uncontrolled)
_____ DIALYSIS
_____ HOSPICE
_____ CONTAGIOUS DISEASE
(Name:) _____

_____ BLIND
_____ SERVICE ANIMAL
_____ LEGALLY BLIND
_____ HEARING IMPAIRED
_____ VISION IMPAIRED
_____ GLASSES

OTHER MEDICAL CONDITIONS / COMMENTS: _____

MEDICATION (please remember that medicine will need to be in the original bottle): _____

ELECTRICAL NEEDED: _____ CONTINUOUS _____ INTERMITTENT _____ NONE

FOOD or DRUG ALLERGIES: _____ YES _____ NO IF YES, PLEASE STATE: _____

MOBILITY

_____ I WALK WITHOUT HELP
_____ I USE A WHEELCHAIR
_____ I OWN A WHEELCHAIR
_____ I USE A CANE
_____ I AM WHEELCHAIR BOUND
_____ I HAVE SOMEONE ASSIST ME WITH ALL MY DAILY ACTIVITIES
_____ I CAN GO TO THE RESTROOM ALONE
_____ I USE A WALKER
_____ I AM BEDRIDDEN
_____ I CAN FEED MYSELF

ADDITIONAL INFORMATION

PEOPLE TO ACCOMPANY YOU TO THE SHELTER: _____ PHONE: _____

DIRECTION TO HOME: _____

COMMENTS: _____

DO YOU OWN A DNR (Do Not Resuscitate): YES NO IF YES, BRING WITH YOU TO SHELTER.

READ AND SIGN

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on the data I have provided, the Hardee County Emergency Management Department in consultation with the Hardee County Health Department will determine which evacuation assistance, if any, this program may be able to provide.

The law permits Hardee County Government, Emergency Services to use and disclose my protected health information, for treatment, payment and health care operations. Understanding the PSN evacuation program is provided at no charge, I also accept responsibility for all expenses associated with any extenuating medical issues that arise.

NAME (print): _____ SIGNATURE: _____

If person completing this form is **NOT** the applicant, please answer the following:

NAME / PHONE: _____ RELATIONSHIP / AGENCY: _____



THANK YOU FOR ALLOWING US TO HELP YOU BE PREPARED.

