Division of
Emergency Management

Palm Beach County Special Needs Shelter Application

APPLICATION DATE:_____

SHELTER INFORMATION

Thank you for your interest in the Palm Beach County Special Needs Shelter. Please understand that the shelter is a place of refuge of last resort from dangerous weather or other emergencies. While basic services such as food, electricity, and medical supervision will be provided; clients and caregivers must provide supplemental food and all medications for the first three days. The shelter cannot provide the appropriate care to ventilator, and certain other patients. Please see page three for accepted diagnoses.

Please remember: Bed height adjustable back hospital cots are provided for clients. Caregivers must provide their own sleeping arrangements.

Return form to: Special Needs Shelter Program Palm Beach County Division of Emergency Management
20 South Military Trail West Palm Beach, FL 33415 OR Fax 561-712-6464. For more information, call 561-712-6400

CLIENT IDENTIFICATION

LAST:_____ FIRST:_____

DATE OF BIRTH:_____/_____/_____ HEIGHT:_____ FEET _____ INCHES WEIGHT:_____

GENDER: □ MALE or □ FEMALE LANGUAGE SPOKEN:_____

HOME PHONE:_____ CELL PHONE: _____

CLIENT RESIDENCE INFORMATION

ADDRESS:_____APT/LOT #:_____

CITY:_____ZIP:_____ E-MAIL:_____

MAILING ADDRESS: □ SAME AS ABOVE _____

CITY:_____ZIP:_____

Do you live above the ground level? □ YES If yes, what floor? _____

DEVELOPMENT NAME:_____ GATE CODE:_____

DWELLING TYPE:
□ SINGLE FAMILY □ DUP/MULTIPLEX
□ MOBILE HOME □ APT/CONDO

CAREGIVER INFORMATION

Patients requiring a caregiver must be accompanied by their caregiver at all times.

Do you have a caregiver who will accompany you to the shelter? □ YES or □ NO

NAME:_____ RELATIONSHIP:_____ PHONE:_____

ADDRESS: _____

CITY:_____STATE:_____ZIP CODE:_____

Does your caregiver have special needs? □ YES or □ NO If yes, explain:_____

_____

EMERGENCY CONTACTS

(LOCAL) NAME: _____RELATIONSHIP:_____PHONE:_____

(NON-LOCAL) NAME:_____RELATIONSHIP:_____PHONE:_____

MEDICAL SUPPORT INFORMATION

PRIMARY DOCTOR:_____ PHONE:_____

HOME HEALTH AGENCY:_____PHONE: _____

HOME MEDICAL EQUIPMENT PROVIDER:_____PHONE: _____

DIALYSIS CENTER:_____PHONE: _____

OXYGEN SUPPLIER:_____PHONE: _____

TRANSPORTATION

Do you need transportation to a special needs shelter? □ YES or □ NO (Arrive on my own)

ASSISTANCE WITH DAILY LIVING NEEDED (Check all ADLs that Apply)

1. Assistance with Daily Living: (check all that apply)

□ Toileting □ Taking Medications □ Feeding/Eating □ Walking more than 50 ft. □ Getting out of bed □ Dressing

2. **Can you sleep on an adjustable back cot?** □ YES or □ NO

SPECIAL NEEDS (check all that apply)

Electrical Needs	Mobility Assessment	Specialized Equipment
□ Bi-Pap or C-Pap □ Cardiac Monitor □ Feeding Pump □ Nebulizer □ Suction Pump □ Oxygen Concentrator □ Oxygen: ____of hours daily at ____liters per minute □ Dialysis: (#)_____days per week	□ I can walk **-or-** **I use:** □ Cane □ Walker □ Wheelchair/scooter □ Lift used to get out of bed □ I am bedridden continuously	□ Feeding Tube □ IV Equipment □ Service Animal (Canine or Miniature Pony) □ Other_____ _____ **□ I need a nurse or caregiver to administer medications.**
Cognitive Assessment	**Vision and Hearing Assessment**	**Special Care/Considerations**
□ Alzheimer's □ Anxiety □ Autism □ Conduct disorder □ Dementia □ Depression □ Mental health problem □ Obsessive Compulsive Disorder □ Psychiatric or personality disorder	□ Hearing Impaired □ Deaf □ Partially Blind □ Blind	□ Ostomy □ Catheter □ Morbid obesity □ Open wounds/Decubitus □ Incontinence □ Wear Adult Diapers

DIAGNOSIS	
Alzheimer's and Dementia	□Progressive Alzheimer's disease (ALZD) (This requires full time trained caregiver) □Psychosis (This requires full time trained caregiver) □Dementia (This requires full time trained caregiver)
Chronic but Stable Illness	□Aphasia (Difficulty communicating) □Cardiac Abnormalities (Controlled with medication and requiring supervision) □Continuous Ambulatory Peritoneal Dialysis (Stable, self care) □Cystic Fibrosis (Assistance with daily living) □Diabetes/Hyperglycemia (Requiring assistance with insulin and monitoring) □Dialysis (Peritoneal and Hemodialysis) (Dialysis not provided in shelter) □Fractured Bones (Pin care/dressing changes) □Neurological Deficit (Monitoring and assistance with daily living) □Obesity □Parkinson's disease (Assistance with daily living) □Seizures (Medication assistance)
Chronic but Stable Illness With Mobility Impairment	□Cerebral Palsy □Cerebral Vascular Accident (Recent CVA) (Wheelchair bound) □Foley Catheter (Requiring Monitoring) □Wheelchair Bound due to Chronic Illness (Such as: ALS, CVA, Multiple Sclerosis, Muscular Dystrophy, etc.)
Electricity Dependant	□Electric Energized Medical Equipment (CPAP, Nebulizers, etc.) □Eating and Swallowing Disorders (Requiring electric equipment) □Sleep Apnea
Oxygen Dependant	□Oxygen Dependant □Chronic Obstructive Pulmonary Disease (COPD) (Requiring oxygen) □Emphysema (Requiring oxygen)

List any other medical problems:_____

_____

Allergies: □ YES or □ NO If yes, list: _____

_____

ATTACH MEDICATIONS LIST (list medication name and dose)

Form Completed By:_____Relationship:_____Phone:_____

By submitting this form, I give my authorization for the Palm Beach County Special Needs program to release this information to other emergency response personnel, human service agencies, officials or those they deem necessary to facilitate the evaluation of this application and required activities to ensure assistance for me. Records relating to registration of disabled citizens are exempt as listed in the provisions of F.S. 119.07 (1), Public Records Law. The information contained herein will be kept confidential. I also understand that assistance will only be provided for the duration of the emergency and that alternative arrangements should be made in advance if I cannot return to my home. Should I require hospital or assisted living care, I understand that I must make these arrangements myself.

_____ _____

Signature of Patient / Guardian Date