

Santa Rosa County Division of Emergency Management

Vulnerable Populations/Special Needs Application

4499 Pine Forest Road Milton, FL 32583

Phone (850) 983-5360

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<u>Division of Emergency Management Only</u>	Date Rec'd: _____	Assigned # _____
Evac Zone: __ Category	Shelter: <input type="checkbox"/> SpNS <input type="checkbox"/> General <input type="checkbox"/> Hosp/Other	Wellness Check: <input type="checkbox"/> FD: _____

<u>Medical Facility/Healthcare Provider</u> : Is the Client requesting? Sheltering services in the event of a disaster? Yes <input type="checkbox"/> No <input type="checkbox"/> To be called for a wellness check? Yes <input type="checkbox"/> No <input type="checkbox"/> Transportation services in the event of a disaster? Yes <input type="checkbox"/> No <input type="checkbox"/>	Home Health Provider: _____ Long-Term Care <input type="checkbox"/> Short-Term Care <input type="checkbox"/> Time frame for Short-Term Care: _____
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Legal name: _____ Primary Phone: _____

Physical Address: _____

Building/Apartment #: _____ City: _____ State: _____ Zip Code: _____

Mailing address if different: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Do you have a Caregiver? Yes No Caregivers Name: _____

Relationship to Caregiver: _____ Caregivers Phone: _____

(A caregiver must accompany you at all times at an evacuation shelter)

Home Health Provider: Yes No

Is Home Health providing Long-term or Short-term care?

If Short-term, what is the time frame for care? _____

Name of Provider: _____ Phone: _____

Physician: _____ Phone: _____

Residence type: Private home Mobile home Villa/Apt/Condo

Living situation: Lives alone Lives with, spouse, relative(s) A caregiver

Emergency contact name (local): _____

Relationship: _____ Phone: _____

How many individuals will be accompanying you to the General Shelter? _____

Are you or anyone accompanying you to the shelter registered as a sexual offender or predator? Yes No

Do you own a pet? Yes No How many? _____ What type? _____

Have you made arrangements for them should you evacuate? Yes No

Cultural

Do you speak English? Yes No Primary Language: _____

Do you need an interpreter? Yes No

List your language in the "Additional Information" section. If your cultural needs are religious, please list them in the "Additional Information" section.

PLEASE FILL OUT ALL SECTIONS BELOW THAT APPLY TO YOUR SITUATION

Sensory

Is the person named on this document;

Blind? Yes No

Deaf? Yes No

Mute? Yes No

Have a trained service animal? Yes No

Please list any special requirements in the “**Additional Information**” section.

Mobility

Walk without help

Use a walker

Use a cane

Use a wheelchair

Fall easily

Invalid (bedridden)

Can you sleep on a cot? Yes No

Other assistive devices

Do you have a friend or family member that can check on you during or after a disaster? Yes No

Wellness Check

If you answered no to the previous question, will you consent to having someone sent to check on you if personnel and time permits? Yes No

This is recommended for those who do not evacuate.

Transportation

Are you requesting transportation to a shelter?

Yes No

If yes, transportation type needed:

Standard Vehicle

Wheelchair Equipped

Ambulance

Will you be accompanied during transport? List in “**Additional Information**”.

Medical

Terminal (Please specify)

Dialysis

Provider: _____

Peritoneal

Hemodialysis

Contagious disease (specify) _____

Incontinence

Self Care

No assistance

Assistance dressing

Assistance eating

Assistance with medication(s)

Caregiver/Relative will assist my needs at the shelter with toileting

Medical Dependence on Electricity & Respiratory Support

Oxygen: ___hrs a day at ___liters via _____

Oxygen concentrator

Nebulizer: ___ times a day

Feeding pump

Continuous positive airway pressure equipment

Suction equipment

Medication requiring

Refrigeration? List in “**Additional Information**”.

Are your medical needs dependent on electricity? List in “**Additional Information**”.

Other

Do you have vulnerabilities not listed in these sections?

Yes No

Please use the “**Additional Information**” section to identify any needs that have not been addressed on this form. This could include dietary or pharmaceutical needs. Include a list of medications.

List name and contact information for any other medical providers, such as home health, hospice, nurse registry, home medical equipment provider, or dialysis center in “**Additional Information**”.

Cognitive

Is the person named on this document unable to care for him/her self?

Yes No

Mental health problems

Confused at times

Please list any special requirements in “**Additional Information**”.

Vulnerable Populations/Special Needs Program

The Santa Rosa County Division of Emergency Management maintains a register of vulnerable populations and special needs requesting assistance during a disaster. In the event of a hurricane or other disaster, the County will attempt to provide sheltering and transportation to them.

It is strongly suggested that you pursue primary evacuation plans with family, friends, neighbors, church organizations, Assisted Living Facilities, Nursing Homes, Hospitals, etc. Shelters should be considered as a **last resort** during a disaster. Please note that you are responsible for all costs associated with medical transportation (ambulance) and medical sheltering, i.e. assisted living facility, nursing home, or hospital. County government cannot assume these costs.

The medical information that you provide on this form will remain confidential. It will only be given to first response agencies associated with your emergency evacuation.

Due to the time required and limited resources to safely and efficiently evacuate vulnerable populations and special needs clients, the evacuation process is executed well in advance of an impending disaster. You must be ready to evacuate when told to do so by emergency officials. **Bring your insurance and pharmacy cards with you.**

Prior to an evacuation, please have your evacuation kit prepared. Include in your kit at least three (3) days' worth of medications and medical equipment that you use. This includes, oxygen, concentrator, tubing, Depends, Chux, urinals, etc. For your convenience it is recommended that you provide your own non-perishable food, water, toiletries and special bedding items.

Pets are only allowed at the pet friendly shelter. The adjacent human shelter may not meet your needs. To ensure pet safety, arrangements for their evacuation should be made well in advance. Ask your veterinarian or local animal shelter about pet sheltering.

I have read the information on this form and I understand the limitation on the services and level of care available. I understand that assistance will be provided only 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 understand that this registration is voluntary and hereby;

- DO request registration with the Vulnerable and Special Needs Populations Program.
- DO NOT request registration with the Vulnerable and Special Needs Populations Program.

*Registrant's Signature: _____ Date: _____

Application must be signed

