Collier County Emergency Management

Special Needs Registry Form

2017

(Please print or type the information and complete all pages. A new registration form should be completed annually.)

This information may also be entered into the Collier County Special Needs Registry by visiting **http://snr.floridadisaster.org**

PERSONAL INFORMATION FOR INDIVIDUAL WITH NEED

Name: ____

(First Name, Mi. Last Name)

Physical Address: ____

City: ____________________________________ State: _______ Zip Code: ________________

Residence Type: ☐ - Single Family Home ☐ - Multi-Family Home ☐ - Mobile Home ☐ - Apartment

Mailing Address: ____

(Please enter if different than your Physical Address)

City: ____________________________________ State: ________ Zip Code: ________________

Email: ____

Primary Phone: (________) _________ - _________________ Is Primary Phone TTY/TTD - ☐

Secondary Phone: (________) ________ - _________________ ☐ - I do not have a phone

Date of Birth (mm/dd/yyyy) _____/______/_____________ Height: ____________

Gender: ____________ Eye Color: _____________ Weight: __________

PERSONAL INFORMATION FOR EMERGENCY CONTACT

Primary Contact Name: ____

(First Name, Mi. Last Name)

Address: ____ City: _______________________ State: ______

Relationship: ☐ - None ☐ - Friend ☐ - Family ☐ - Neighbor ☐ - Caregiver Zip Code: ___________________

Email: ____

Primary Phone: (______) ______________________ Secondary Phone: (______) ________________________

Secondary/Out of Area Contact Name: ____

(First Name, Mi. Last Name)

Address: ____ City: _______________________ State: ______

Relationship: ☐ - None ☐ - Friend ☐ - Family ☐ - Neighbor ☐ - Caregiver Zip Code: ___________________

Email: ____

Primary Phone: (______) ______________________ Secondary Phone: (______) ________________________

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Additional Contact Information

Physician Information

Name: ____ Phone: (______) _____________________

Caregiver Information

Name: ____ Phone: (______) _____________________

Home Health Care Information

Name: ____ Phone: (______) _____________________

Pharmacy Information

Name: ____ Phone: (______) _____________________

Evacuation Assistance Information

- ☐ Blind/Low Vision
- ☐ Deaf/Hard of Hearing
- ☐ Behavioral Health Issues
- ☐ Contagious Disease
- ☐ Frail/Elderly
- ☐ Speech Impediment
- ☐ Physical Disability
- ☐ Bedridden
- ☐ Mentally/Memory Impaired
- ☐ Mild Dementia/Alzheimer's
- ☐ Moderate Dementia/Alzheimer's
- ☐ Severe Dementia/Alzheimer's
- ☐ Hemodialysis at Facility
- ☐ Hemodialysis at Home
- ☐ Peritoneal Dialysis
- ☐ Requires Constant Skilled Nursing Care
- ☐ Assistance with Medications
- ☐ Assistance needed with Insulin
- ☐ Requires Refrigerated Meds
- ☐ Autism
- ☐ Special Dietary Needs/Restrictions
- ☐ Seizures
- ☐ Other

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Communication Limitations

- ☐ Does Not Have Radio
- ☐ Does Not Have Television
- ☐ Does Not Telephone, TTY, or VRI
- ☐ Does Not Have Access to Internet
- ☐ Does Not Speak English (Spanish/Creole/Other)

Transportation Needs

- ☐ Car
- ☐ Bus
- ☐ Wheelchair Van
- ☐ Ambulance

Has Difficulty Walking and Requir

- ☐ Walker / Cane
- ☐ Standard Wheelchair
- ☐ Motorized Scooter
- ☐ Attendant to Assist in Walking
- ☐ Requires Stretcher Transportation
- ☐ Hoyer Lift

Oxygen Dependent

- ☐ 24 Hour
- ☐ Only Overnight
- ☐ Nebulizer
- ☐ CPAP
- ☐ Other (Type/Liters)

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Requires Medical Equipment That Is Not Easily Transportable

- ☐ Ventilator
- ☐ Suction Machine
- ☐ Catheters
- ☐ Feeding Tube
- ☐ Oxygen Concentrator
- ☐ Other Equipment

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Required Assistance

1. Are ALL of the support needs resulting in the need for evacuation assistance temporary? (Example: The individual is bedridden due to pregnancy difficulties, but is expected to be fully recovered after the baby is delivered.) ☐ - Yes ☐ - No, the condition(s) are expected to be permanent.
2. Is the person in need a seasonal resident? ☐ - Yes ☐ - No From: ___________ to ____________
3. Does the person in need require evacuation assistance 24 hours/day? ☐ - Yes ☐ - No
4. Does the person in need have a 24 hour caregiver? ☐ - Yes ☐ - No
   a. Will the caregiver travel and/or stay with you? ☐ -Yes ☐ - No

Collier County mandates you bring a caregiver with you to the Special Needs Shelter

Medication List

In lieu of filling out this section of the registration, you may attach a copy of your medication list from your Doctor or Pharmacy. If using this form, please list medication information below.

Medication Name	Dosage	Frequency

Service Animals

Name: ________________________________ Type: ☐ - Dog ☐ - Miniature Horse ☐ - Cat ☐ - Other

Pets

Name: ________________________________ Type: ☐ - Dog ☐ - Miniature Horse ☐ - Cat ☐ - Other

Name: ________________________________ Type: ☐ - Dog ☐ - Miniature Horse ☐ - Cat ☐ - Other

Name: ________________________________ Type: ☐ - Dog ☐ - Miniature Horse ☐ - Cat ☐ - Other

If you are using Domestic Animal Services Pet Shelter during an evacuation - please remember to have your pet ready in a carrier with a leash and food for at least 3 days.

IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING

- The information contained herein is true and correct to the best of my knowledge. I have read and understand the information on this form as well as the attached Guidelines document.
- I understand that: The registration is voluntary and hereby request registration in the “Special Needs Program”.
- Emergency shelters are made available to provide protection during a period of immediate danger.
- I am required to bring a caregiver while at the shelter.
- I have a copy of the Special Needs Program Guidelines and will take the things that I need with me to the shelter should I choose to go.
- I will ensure that a pet carrier or crate and necessary items is available for my pet being taken to or going to the pet shelter.
- Limited volunteer nursing, medical assistance, supplies, and equipment at the Special Needs Shelter will be available to assist me and/or my caregiver.
- I understand that I will need to make alternative arrangements in the event that I am unable to return to my home after the storm.
- I will be responsible for any charges and costs associated with hospitalization or other medical facilities including care and medical transportation, if they should become needed.
- Transportation: I may be asked to evacuate my residence. All reasonable attempts will be made to give advance notice by phone of the date and time expected to be picked up for transport to the Special Needs Shelter. Monitor government TV (Channel 97), Local TV stations or Local Radio Stations for updated hurricane information. If I decline transportation when the transporter arrives, I will be required to sign a “Refusal Form”. I understand that upon declining transportation, I may not have another opportunity to request this service.
- I agree to opt-in to receive Collier County Emergency Management’s automated telephone notifications and or texts prior to and after an emergency. This will include occasional tests to make sure our system is up to date and functional.

By signing, I grant permission to health care providers, transportation agencies, and responders as necessary to provide care, and to disclose any information that is necessary to respond to my needs.

______________________________ ______________________
Signature of Registrant/Authorized Caregiver/Person Completing the Form Date

Please complete and return form to:

Collier County Emergency Management
8075 Lely Cultural Pkwy Suite 445
Naples, FL 34113

Or scan and email to:

EMHumanServices@colliergov.net