Florida Special Needs Registry
Registration Information - Collier County

Instructions: Complete this form and fax or mail it to Collier County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered on line. Required fields are indicated with an asterisk (*).

Mail: Collier County Special Needs Registry
8075 Lely Cultural PKWY
Suite 443
Naples, FL 34113

Fax: (239) 252-3700

PERSONAL INFORMATION ABOUT THE REGISTRANT	
*First Name	
Middle Name	
*Last Name	
Suffix	
*Birth Date	
*Gender (select only one)	☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer Not To Provide
*Height	Feet: Inches:
*Weight (pounds)	
Living Situation (select only one)	☐ Live alone ☐ Live with relative or caregiver ☐ Other living situation
*Primary Language	
Secondary Language	
Veteran	☐ Yes ☐ No
Last 4 digits of SSN	
Email Address	
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	☐ Family Member ☐ Caregiver ☐ Neighbor ☐ Friend ☐ Home Health Care Provider ☐ County Emergency Management Staff ☐ County Health Department Staff ☐ DOH State Staff
Additional County Information	
*What year is this registration for? (select only one)	☐ 2020 ☐ 2021 ☐ 2022 ☐ 2023 ☐ 2024 ☐ 2025

ADDRESS FOR THE REGISTRANT (physical address is required)	
*Physical Address (cannot be a PO Box)	
Apt #, Unit #, Bldg #, Suite #, etc.	
*Physical City	
*Physical State	FL
*Physical Zip Code	
Name of Complex, Subdivision or Mobile Home Park	
Is the home at this address a mobile home?	☐ Yes ☐ No
Is the home at this address a highrise or multi-story home?	☐ Yes ☐ No

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ADDRESS FOR THE REGISTRANT (physical address is required)	
Does this home have stairs?	☐ Yes ☐ No
Is there a gate that requires a code to enter?	☐ Yes ☐ No
Do you live at this address year round?	☐ Yes ☐ No If No, from month:_____ To month:_____
Mailing Address (if different from above)	
Mailing City	
Mailing State	
Mailing Zip Code	

Additional County Information	
What is your hurricane evacuation zone? (This question is not required. Follow this link to learn about your zone copy and paste this link: https://collierbcc.maps.arcgis.com/apps/InformationLookup/index.html?appid=2299a87f637b422c95661c889 (select only one)	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

PHONE NUMBERS FOR THE REGISTRANT (a primary and at least one other phone number is required)

*Phone Number	Extension	*Phone Type (select only one)	Primary	TTY/TDD Capable
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No

PRIMARY EMERGENCY CONTACT FOR THE REGISTRANT (required)	
*Primary Emergency Contact Name	
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	

OTHER CONTACTS FOR THE REGISTRANT (entry is optional)	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact
Contact Address	

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OTHER CONTACTS FOR THE REGISTRANT (entry is optional)	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	
*Other Contact Name	
*Contact Type (select only one)	☐ Secondary Emergency Contact ☐ Caregiver ☐ Family Member ☐ Neighbor ☐ Friend ☐ Physician ☐ Pharmacy ☐ Home Health Care Provider ☐ Home Medical Equipment Provider ☐ Hospice Provider ☐ Oxygen Provider ☐ Dialysis Clinic ☐ Other Medical Provider ☐ Out Of Area Contact
Contact Address	
Contact City	
Contact State	
Contact Zip Code	
*Contact Primary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Secondary Phone Number	( ) - Extension:
Is this phone TTY/TDD capable?	☐ Yes ☐ No
Contact Email Address	
Additional County Information	
*Will you have a caregiver stay with you at the Special Needs Shelter?	☐ Yes ☐ No
*If yes, what is the name of the caregiver that will stay with you at the Special Needs Shelter? (If not applicable please put N/A)	
*If yes, what is the telephone number of the person that will stay with you at the Special Needs Shelter? (If not applicable, then enter (999) 999-9999)	( ) -

REGISTRANT'S PETS						
*Pet Name	*Type of Animal	*Breed / Description	Vaccinations Up to Date	Will Bring to Shelter	Requires Medication	Other information about this pet
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

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REGISTRANT'S PETS						
*Pet Name	*Type of Animal	*Breed / Description	Vaccinations Up to Date	Will Bring to Shelter	Requires Medication	Other information about this pet
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

REGISTRANT'S SERVICE ANIMALS			
*Animal Type (select only one)		*Required Due to Disability	*Work or Task Animal has been trained to perform
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	
☐ Dog	☐ Miniature Horse	☐ Yes ☐ No	

REGISTRANT'S EQUIPMENT				
Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	☐ Apnea Monitor	☐ Cardiac Monitor	☐ CPAP / BiPAP	☐ Dialysis Catheter
	☐ Feeding Pump	☐ Medication that requires refrigeration	☐ Nebulizer	☐ Oxygen Concentrator
	☐ Suction Pump	☐ Ventilator	☐ Wound Vac	
	Other:			
Please indicate any medically necessary equipment that is NOT electric dependent for this registrant: (select all that apply)	☐ Indwelling Urinary Catheter	☐ Insulin Pump	☐ Peripheral Intravenous Line	☐ PICC Line
	☐ Port-a-Cath	☐ Pulse Oximeter	☐ Tracheostomy	

TRANSPORTATION & MOBILITY				
Registrant has the following transportation needs: (select all that apply)	☐ Can be transported in a car	☐ Can be transported in a bus	☐ Must be transported in a wheelchair accessible vehicle	☐ Must be transported in a stretcher van
	☐ Uses a wheelchair but can transfer to a van seat	☐ Weight requires special transportation	☐ Needs continuous oxygen during transport	☐ Just needs transportation to a shelter
Registrant has the following mobility issues: (select all that apply)	☐ Needs help to walk	☐ Needs help to get into/out of a cot	☐ Uses a lift to get out of a cot	☐ Is confined to a bed
	☐ Is paralyzed (complete or partial)	☐ Uses a Walker	☐ Uses a Cane	☐ Uses a Wheelchair
	☐ Uses a Motorized Wheelchair / Scooter			
	Other:			
Additional County Information				
*Do you require that transportation to an evacuation center be provided for you?	☐ Yes	☐ No		
*If you need transportation assistance, please state why. (select all that apply)	☐ I do not have a car.	☐ I am unable to walk to a bus pick up point.	☐ I do not have anyone that can drive me.	☐ My medical needs prevent me from evacuating on my own.
	☐ I do not need transportation.			
*How many people need to be evacuated? (if not applicable, put N/A)				

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MEDICAL & OTHER	
Behavioral: (select all that apply)	☐ Autism ☐ Bipolar ☐ Combative / Violent ☐ Conduct Disorder ☐ Obsessive / Compulsive ☐ Personality Disorder ☐ Psychosis ☐ Schizophrenia ☐ Self-injurious or danger to others ☐ Substance Abuse Other:
Memory: (select all that apply)	☐ Alzheimer and related dementias ☐ Dementia ☐ Memory Impaired
Dialysis: (select all that apply)	☐ Hemodialysis (Facility/Home) ☐ Peritoneal Dialysis
Dialysis Frequency: (select only one)	☐ 1 time a week ☐ 2 times a week ☐ 3 times a week ☐ 4 times a week ☐ 5 times a week ☐ 6 times a week ☐ 7 times a week (daily)
Oxygen Type: (select only one)	☐ Gaseous ☐ Liquid
Oxygen Liter Flow / Amount: (select only one)	☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ 3.5 ☐ 4.0 ☐ 4.5 ☐ 5.0 ☐ 5.5 ☐ 6.0 ☐ 6.5 ☐ 7.0
Oxygen Mode of Administration: (select only one)	☐ Mask ☐ Nasal Cannula ☐ Trach Collar
Medication Allergies & Reactions (list all)	
Do you need assistance with administering your medications?	☐ Yes ☐ No
Other: (select all that apply)	☐ Vision Impaired ☐ Partially Blind ☐ Legally Blind ☐ Hearing Impaired ☐ Deaf ☐ ALS ☐ Arthritis / Osteoporosis ☐ Anxiety ☐ Angina ☐ Asthma ☐ Bedsore (Decubitus Ulcer) ☐ Cancer ☐ Cerebral Palsy ☐ Congestive Heart Failure ☐ COPD ☐ Cystic Fibrosis ☐ Diabetes ☐ Incontinent ☐ IV Pump ☐ Flight Risk ☐ Non verbal ☐ Difficulty understanding verbal instructions ☐ Emphysema ☐ Heart Disease ☐ High Blood Pressure ☐ Kidney Disease ☐ MS ☐ Ostomy (Colostomy, Ileostomy, Urostomy) ☐ Pacemaker / AICD ☐ Parkinsons ☐ Peritoneal Dialysis Pump ☐ Seizures ☐ Stroke Contagious Disease: Food Allergies & Reactions: Other:
Name of Primary Insurance Company:	
Insurance ID #:	
Medicare #:	
Medicaid #:	

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Additional County Information	
*Do you give permission for medical information to be shared with alternate contacts other than your primary contact?	☐ Yes ☐ No

REGISTRANT'S MEDICATION (Use additional paper if more space needed)

*Name of Medication	Dosage	Route	Requires Refrigeration
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No
		☐ Auto Injector ☐ Injection ☐ IV ☐ Mouth ☐ Subcutaneous ☐ Sublingual ☐ Transdermal	☐ Yes ☐ No

OTHER NOTES ABOUT THE REGISTRANT

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