

Putnam County Special Needs Shelter Application/Registration

Please return this completed form to: Nursing Director, Putnam County Health Department, Special Needs Registration, 2801 Kennedy Street, Palatka, Florida 32177.

NAME Last: _____ First: _____ Middle: _____

Residence Type: Mobile/manufactured Single Family Apartment/Condo Other: _____

Street Address: _____

Apartment #: _____ Building # _____ Name of Complex or Sub-Division _____

City: _____ State: _____ ZIP: _____ County of residence: _____

Mailing address if different than above: _____

Phone #: _____ Alternate Phone # _____

DOB: _____ Age: _____ (years) Sex: Male Female Weight: _____ (lbs) Height: _____ (ft.) _____ (inches)

Primary Language: _____

Living Situation: Alone Relative Care giver Other _____

Emergency Contacts: Local: _____ Relationship: _____ Phone: _____

Non - Local: _____ Relationship: _____ Phone: _____

Transportation (Evacuation Assistance)

I require transportation: Yes No

Transportation Needs: Car Bus Wheelchair Van Ambulance
 Other: _____ Number of Persons to Transport: _____

If the application is to request transportation/evacuation assistance only, you are not required to complete the following information

Special Medical Needs of Applicant

Will you be accompanied to the Special Need Shelter? Yes No

If yes, number of care givers/ family members accompanying Individual to the SpNS: _____

<p>Medically Dependent On Electricity:</p> <p><input type="checkbox"/> O2 Concentrator <input type="checkbox"/> Feeding Pump</p> <p><input type="checkbox"/> Suction</p> <p><input type="checkbox"/> Other: _____</p>	<p>Oxygen Dependent:</p> <p><input type="checkbox"/> 24 hour <input type="checkbox"/> Only Overnight <input type="checkbox"/> Intermittent</p> <p>Oxygen Type: _____</p> <p>Mode of administration</p> <p><input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Mask</p> <p>Liters flow: _____ L /minute</p>
<p><input type="checkbox"/> Assistance with medications</p> <p><input type="checkbox"/> Medication requiring refrigeration</p> <p><input type="checkbox"/> Insulin Dependent</p> <p><input type="checkbox"/> Assistance needed with wound care. Specify: _____</p>	<p><input type="checkbox"/> Mental Health Problems: _____</p> <p><input type="checkbox"/> Cognitive Impaired: _____ (i.e., Alzheimer's, dementia)</p> <p><input type="checkbox"/> Has behavioral challenges: Specify: _____</p>

List any assistive devices such as glasses, white cane, hearing aid.

Vision Loss/ Impaired _____

Hearing Loss/Impaired _____

ASL

Speech Impaired _____

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<input type="checkbox"/> Incontinence <input type="checkbox"/> bowel <input type="checkbox"/> bladder	<input type="checkbox"/> Mobility Impaired <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches <input type="checkbox"/> Other: _____	<input type="checkbox"/> Dialysis Dependent <input type="checkbox"/> Peritoneal (PD) <input type="checkbox"/> Hemodialysis Schedule: _____
<input type="checkbox"/> Other Health Impairments: _____ _____	<input type="checkbox"/> Trained Service Animal Type of Animal: _____ 1. Is the animal trained? _____ 2. What does the animal do for the client? _____	

Medical Information:

Primary Doctor: _____ Phone: _____
 Home Health Agency: _____ Phone: _____
 Home Medical Equipment (HME) Provider: _____ Phone: _____
 Oxygen Company (if different than HME): _____ Phone: _____
 Dialysis Center: _____ Phone: _____
 Pharmacy: _____ Phone: _____

Assigned to Hospice: Name of Hospice: _____ Phone: _____

List Routine Medications (both prescription and over the counter)

List Medical Conditions: _____

By signing this form I give my authorization for medical information contained herein to be released to the county health department, emergency management, local fire districts and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt from the provisions of F.S. 119.07 (1), Public Records Law. The information contained here will be kept confidential.

Signature: _____ Date: _____

Print Name: _____

Annual/yearly registration is required no later than the date of application each year

Do not write below this line: For Internal use Only
