OKEECHOBEE COUNTY
SPECIAL NEEDS SHELTER REGISTRATION REQUEST FORM

Submit Completed Forms to:

Okeechobee Emergency Management,
Special Needs Shelter Registry
707 NW 6th Street
Okeechobee, FL 34972
Phone 863-763-3212

****ALLERGIES****

_____

_____

_____

_____

_____

TO BE COMPLETED BY TRIAGE PERSONNEL

Verification of Attendance (Y or N) _____

(No) Plan_____

Client has: √
Medication _____
Allergies _____
Food/Snacks _____
O2-Concentrator _____
DNRO _____

RN Reviewed (Last Name) _____

A New Form must be submitted annually beginning January 1st

Name: (Please Print) _____ County of Residence: _____

Street Address: _____ City: _____

Zip: _____ Phone Home_____ Cell #: _____

☐ Male ☐ Female Height: _____ Weight: _____ lbs. Age: _____ Date of Birth: _____

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other – Specify _____

Home Care Information

☐ I take care of myself at home ☐ I need part time nursing help at home

☐ I am unable to care for myself at home ☐ I have full time nursing help at home

Type of Residence: ☐ Single Family Home ☐ Manufactured Home ☐ Apartment/Condo

Complex/Park Name: _____Office Phone _____

Caregiver who will be assisting me in the shelter (REQUIRED):

Caregiver Name: _____ Relationship _____

Caregiver's Phone Number Home #_____ Cell #_____

Medical Provider Information (REQUIRED)

Primary Care Doctor: _____ PH#: _____

Home Health/Hospice Agency: _____ PH#_____

Oxygen Provider: _____ PH#: _____

Other Medical Support Providers

Pharmacy Name: _____ PH#: _____

Home Medical Equipment: _____ PH#: _____

Dialysis _____ PH#: _____

Revised 5/2021

SPECIAL/MEDICAL NEEDS – Please mark all that apply

- ☐ Wound care daily or more often (if checked please specify the type of wound: _____
- ☐ Ostomy care assistance
- ☐ Catheter care assistance
- ☐ Suction equipment
- ☐ Feeding Pump
- ☐ Assistance from RN with medication or injections
- ☐ Assistance from RN with insulin or blood sugar check
- ☐ RN to assist with IV's (**Include copy of order from Dr.)**
- ☐ Ventilator dependent (stable)
- ☐ Medicines that require refrigeration

Oxygen or Electricity Dependence

☐ Medical electrical equipment required to maintain health status (Check all that Apply):
☐ CPAP/ BI-PAP ☐ Nebulizer
☐ Other: _____
☐ Oxygen dependent: ☐ 24 hr. ☐ Nighttime Only
☐ PRN (As needed)
Liters per minute:_____

OTHER NEEDS - Please mark all that apply (Bring these items with you when going to the shelter)

☐ Glasses ☐ Cane ☐ Walker ☐ Wheel chair ☐ Electric wheel chair
☐ Hearing aid(s) ☐ Right Ear ☐ Left Ear ☐ Both Ears
☐ Trained service animal (if checked please specify the type of Animal): _____
What work or task has the animal been trained to perform? _____

ADDITIONAL MEDICAL INFORMATION – Please mark all that apply

- ☐ Seizures
- ☐ Diabetes
- ☐ Cardiac please specify: ☐ Congestive Heart Failure ☐ Angina ☐ High Blood Pressure
- ☐ Stroke ☐ Other Cardiac Condition (if checked, please specify): _____
- ☐ Dialysis (if checked, please specify): ___ Hemodialysis ___ Peritoneal
- ☐ Quadriplegic or Paraplegic (if checked, please specify): _____
- ☐ Mental Illness / Anxiety / Depression (if checked, please specify): _____
- ☐ Alzheimer's /Dementia **(if checked, a caregiver MUST be present at all times during sheltering.)**
- ☐ Immune System Problems (If checked, please specify): _____
- ☐ Bed bound ☐ Unable to transfer bed to chair
- ☐ Unable to hold urine or bowel movements until bathroom is reached
- ☐ Do Not Resuscitate Order (DNRO) **(Bring the original with you)**

Transportation Needs (REQUIRED)

- ☐ I (we) have our own transportation and will drive to the shelter
- ☐ I (we) request transportation via van.
- ☐ I (we) request transportation via van/wheelchair lift
- ☐ I (we) request transportation via ambulance stretcher

If you are requesting transportation assistance, please answer the following questions:

If using a wheelchair, can you transfer to a van seat? ☐ Yes ☐ No
If a stretcher is needed, please explain why_____
List equipment that will be transported (oxygen concentrators, etc.): _____
_____
_____

How many people are going to the Special Needs Shelter: _____ Number to be picked up: _____

Alternative Arrangements (REQUIRED)

Should your home sustain damage and you are not able to immediately return, please identify what your alternative plans are. You should include the names of those with whom you could stay until you can return to your home (it could be a friend or relative). Please list their names and contact numbers (including cellular numbers). It is advisable to list at least one "Non-Local" contact in the event that our area needs to be evacuated. (Please use another sheet of paper if you need more space) Sheltering Plans: _____

_____

_____

Alt. Contact Person 1: _____ PH#: _____

Alt. Contact Person 2: _____ PH#: _____

Non-Local Contact Person: _____ PH#: _____

MEDICATIONS

Please list your medications, your dosage, full name of the doctor who prescribed the medication and the doctor's phone number. **Attach additional sheet of paper or a printout from the pharmacy if necessary.**

Please list ALL medications or provide a printed list with request form.

NAME OF MEDICATION	DOSAGE	FULL NAME OF PRESCRIBING PHYSICIAN	PHYSICIAN'S PHONE NUMBER (include area code)

******THIS REGISTRATION FORM MUST HAVE A SIGNATURE******

_____ _____

Signature of Registrant or Caregiver Date

Revised 5/2021

TO BE COMPLETED BY OKEECHOBEE COUNTY EM STAFF ONLY

Criteria Requirement

□ Basic criteria met for SpNS
- □ Refer to Health Dept. for Verification
- □ Send Approval/Alternate Placement letter

□ Does Not Meet Basic Criteria for SpNS
- □ Send General Shelter Letter

EM Initials: _____ Date: _____

TO BE COMPLETED BY OKEECHOBEE COUNTY HEALTH DEPARTMENT STAFF

Level of Care

□ Meets basic criteria for SpNS

□ Exceeds Level of Care & Requires Alternative placement
- □ Nursing Home: _____
- □ Assisted Living Facility: _____
- □ Other: _____

DOH Initials: _____ Date: _____

***** To be completed by Discharge Planner *****

Discharge Planning (Plans If Client Cannot Return Home)

□ Returning Home

□ Returning to Another Family Member's Home

□ Other Location (Friend, Hotel, Hospital, Nursing Home): _____

Discharge Address: _____

Name of person discharged to: _____

Phone Number(s): _____

Contact Person: _____

Phone #: _____

Contact Person (Non-Local): _____

Phone #: _____

Discharge Checklist

□ Electricity to Area & Home Restored □ Road to Home Cleared & Open

Verified by: _____

□ Transportation Arranged & Notified (if needed)

Transportation Provider: _____

□ Equipment & Personal Belongings Packed

Name of Discharge Planner_____

Signature_____

Discharge Date_____ Time: _____

Mode of Discharge _____

Additional Comments: _____

_____

Follow up Needed: □ Yes □ No

Please initial each line to indicate that you have read and understand this important notice and statement of understanding in regards to the Okeechobee County Special Needs Shelter program. A copy of this page will be returned to you once the eligibility review has been completed.

IMPORTANT NOTICE AND STATEMENT OF UNDERSTANDING (REQUIRED)

I, _____ (print patient name) do understand that:

Initial each line below

- Emergency shelters, including the special needs shelter, are made available by the County to provide me with protection and should be considered a shelter of last resort (if NO other options are available).

- Limited nursing and medical assistance in the Special Needs Shelter will be available to assist me and/or my caregiver.

- Due to the limitation of services and conditions in a shelter, the level of services will not equal what I receive at home; and conditions in the shelter may be stressful and/or inadequate for my needs.

- Clients and caregivers are responsible to provide for their own basic and special needs while in the shelter.

- Clients will be accommodated on simple cots. Bedding will not be provided. Air mattresses, hospital beds, lawn and lounge chairs cannot be allowed due to the lack of space.

- One person should accompany the client as a caregiver. Caregivers will be provided a chair. Unfortunately, cots cannot be provided to caregivers because this would limit the shelter capacity for clients.

- Clients must bring medications (in their original containers), all medical supplies and medical equipment (including oxygen concentrators) with them to the shelter.

- Food and water may not be provided. Client may bring special dietary items. All food items must be non-perishable and last up to 5 days. There is no access to a refrigerator, stove or a microwave at the shelter.

- Clients and caregivers should bring personal hygiene items and extra clothing for up to 5 days. Keep in mind that space is limited. Make sure the clients name is on all items brought to the shelter. Clients/caregivers are responsible for their own items.

- Clients and caregivers will not be permitted to smoke or use any tobacco products in the shelter or on the shelter grounds.

- Pets are not permitted in the Special Needs Shelter. Clients should make other arrangements for the care of their pets prior to their stay at the shelter. However, trained service animals are allowed in the shelter and

a 5-day supply of food (non-perishable) and water should accompany the animal. Service animals must be under control of the client/handler at all times.

- Clients with living wills, a power of attorney, and a Do Not Resuscitate Order (DNRO) should bring the original with them to the shelter.
- Transportation is coordinated through Okeechobee County Emergency Management to the Special Needs Shelter only. All attempts will be made to give advanced notice by telephone of the date and time to expect to be picked up for transport to the shelter. If I decline transportation when the transporter arrives, I understand that I may not have another opportunity to request this service.
- I will be responsible for any charges and costs associated with hospitalization or other medical facility including care and medical transportation, if they should become needed.
- I will need to make alternative arrangements in the event that I am unable to return to my home after the emergency.
- I grant permission to all of my healthcare providers, transportation agencies, medical equipment providers and others as necessary to provide care, and to disclose any information that is necessary to respond to my needs.
- I understand that this registration is voluntary, and does not guarantee in any way my eligibility for the Special Needs Shelter.
- I understand that my medical, electrical, and oxygen needs may be verified by my doctor.

SIGNATURE

I have read, understood, and received a copy of the above "Important Notice and Statement of Understanding".

I grant permission to all health care providers, transportation agencies, oxygen providers, and others as necessary to provide care, and to disclose any information that is necessary to respond to my needs.

I understand that this registration is voluntary and I hereby request registration in the Special Needs Shelter.

Signature of Registrant or Caregiver **Date**