Transportation and Special Needs Shelter Application
Brevard County Emergency Evacuation Registry

HEALTHCARE AGENCY:______________________________ Phone:_________________________

Contact person:____

FOR OFFICE USE ONLY

TRANSPORT TYPE:	☐ BUS	☐ LIFT- GATE	☐ OTHER	
TRANSPORT AGENCY:	☐ SPACE COAST	☐ COASTAL	☐ PRIVATE VEHICLE	
SHELTER LEVEL:	☐ GENERAL	☐ ASSISTED CARE	☐ ENHANCED CARE	☐ 24 HR VENT PATIENT

SHELTER LOCATION: ______________________ Patient notified of Registration: Date:______________

Please complete this form and return to: Brevard County Emergency Management
1746 Cedar Street, Rockledge, FL 32955
321-637-6670 (P) 321-633-1738 (F)

COMPLETE ONE APPLICATION PER PERSON - THIS IS A VOLUNTARY PROGRAM
Transportation is free to all Red Cross Shelters and Special Needs Shelters.

DO YOU NEED TRANSPORTATION TO A SHELTER?

☐ **No - (private vehicle)**
☐ **Yes**
☐ **Yes, TRANSPORTATION ONLY TO A RED CROSS SHELTER- I HAVE NO SPECIAL NEEDS MEDICAL CONDITIONS**

Please check one of the following:

☐ I can walk to, on, and off of a bus
☐ I am mobile with an assistive device (walker/cane)
☐ I require a wheelchair lift vehicle Check: ☐ Wheelchair ☐ Electric Scooter ☐ Other___________
I Can Transfer to a seat/chair ☐ Yes ☐ No
☐ I am bedridden and require a stretcher and cannot transfer to a wheelchair for transport

Please check if you have a hearing impairment, vision impairment, or both:

☐ I am hearing impaired
☐ I have a vision impairment
☐ I have a hearing and vision impairment

IF YOU ARE ONLY REQUESTING TRANSPORTATION TO A RED CROSS SHELTER-Please only fill out Section A Personal Information and Section B Evacuation Information
ALL SPECIAL NEEDS CLIENTS FILL OUT ENTIRE FORM

PERSONAL INFORMATION (Section A)

Last Name:_________________________ First Name:__________________ MI:________

Birth Date:___________ Sex: ☐ Male ☐ Female Height: _______ Weight:________

Primary Language: ☐ English ☐ Spanish ☐ Other _________

Living Situation: ☐ Alone ☐ With a Caregiver ☐ Am a Caregiver

Home Address:_______________________________________ Apt./ Lot No.___________

Mailing Address (if different from above):____

City:___________________ Zip Code:______________Phone: (___)_______________

Alternate Phone:(___)_______________

Residence Type: ☐ Private Home ☐ Apartment/ Condo ☐ Manufactured/ Mobile Home

If you live in an apartment or condo, do you live above the first floor? ☐ Yes/Which floor? _____ ☐ No

Name of Complex/ Subdivision/Condo or Development:___________________________

Name of Caretaker/ Companion: _______________________ Phone:______________

Contact Person **NOT** living with you in case of an emergency while evacuated:

Name:______________________ Relation:_________Cell Phone:____________

Home Phone: _____________________Work Phone:_______________________

EVACUATION INFORMATION (Section B)

My spouse will evacuate with me: ☐ Yes Name: _________ ☐ No My caretaker: ☐ Yes ☐ No

Other person(s), if any, accompanying you to the shelter: _________________

PETS ARE NOT ALLOWED IN SHELTERS. MAKE EVACUATION-SHELTERING ARRANGEMENTS FOR YOUR PET NOW!

Do you have a dog(s): ☐ Yes ☐ No How many: ____ Cat(s): ☐ Yes ☐ No How many? _____

Do you have a service animal? ________ If so, type _____________________________

******TRANSPORTATION ONLY INDIVIDUALS STOP HERE- PLEASE GO TO THE LAST PAGE AND SIGN******

PLEASE CHECK ALL MEDICAL CONDITIONS THAT APPLY

Do you require assistance with taking your medications? ☐ No ☐ Yes Type of assistance:________________

Please bring all current medications with you to the shelter

ASSISTED CARE SHELTER

(may require medical assistance)

- ☐ Colostomy -medical assistance needed
- ☐ Catheter - medical assistance needed
- ☐ Oxygen
  - ☐ Liquid Oxygen
  - ☐ Gaseous Oxygen
  - ☐ Rate:_________
  - ☐ Mode of Administration:____________
- ☐ Nebulizer - more than 1 treatment a day
- ☐ Cognitive Impairments (Alzheimers, etc.)
  Type: _____________________________________
- ☐ Psychiatric Impairment
  Type: _____________________________________
- ☐ Dressing Changes Wet to Dry-medical assistance needed
- ☐ Seizure Activity within the last 6 months
- ☐ Bladder & Bowel dysfunction

- ☐ Trach Tube - that may require suction
- ☐ Brittle Diabetic - medical assistance needed
- ☐ Apnea Monitors
- ☐ Dialysis
  - ☐ Peritoneal / ☐ Hemo
  - Frequency _____________
- ☐ Sensory Loss or Impairment
  Assistive Device: _________________
- ☐ Mobility Impairment
  Assistive Device: _________________
- ☐ G-Tube-feeding

Hospitalized in last 3 months for:

- ☐ Congestive Heart Failure
- ☐ Shock due to Internal defibrillator
- ☐ Open Heart Surgery

ENHANCED CARE SHELTER

(requires medical assistance)

- ☐ Imminent Death
- ☐ Hospice
- ☐ Bedsores

OTHER

- ☐ 24 Hour Ventilator Patient

PLEASE PROVIDE CONTACT INFORMATION FOR YOUR MEDICAL SUPPORT PROVIDERS, IF ANY. (EXAMPLES: HOME HEALTH AGENCY, MEDICAL EQUIPMENT PROVIDER, PRIMARY DOCTOR, ETC.)	
NAME OF AGENCY/PROVIDER	**PHONE NUMBER**

MEDICAL EQUIPMENT YOU USE THAT IS POWER DEPENDENT	PLEASE PROVIDE A LIST OF ALL CURRENT MEDICATIONS

POWER IS NOT GUARANTEED

1. I understand that a Special Needs Shelter does not provide beds, cots, or lifts, and that I should bring my own to the extent I am capable.
2. I grant permission to medical providers, transportation agencies, and others as necessary to provide care and disclose any information necessary to respond to my needs.
3. I understand that assistance will only be provided for the duration of the evacuation.
4. I understand that in the event I am not able to return to my home that I will be responsible for any additional transportation or hospital expenses.
5. I understand that upon order or recommendation to evacuate my residence, if I have requested transportation, I will receive advance notice, by phone, of the date and time to expect to be picked up for transport to a shelter.
6. If I decline transportation when a transporter arrives, I understand that I may not have another opportunity to obtain this service.
7. I understand that based on this application and the data I have provided; the Office of Emergency Management will determine if any emergency evacuation assistance will be provided.
8. I understand that power is not guaranteed, due to unforeseen power fluctuations or power failures.
9. I understand that my caregiver (if one is assigned) should be present during my stay at the Special Needs Shelter.

I certify that this information is correct to the best of my knowledge.

________________________________ ________________

Applicant Signature Date

If the person filling out this form is not the patient, please answer the following:

Name:__________________________ Phone:____________________

Relationship/ Agency: ________________________________

APPLICATIONS ARE TO BE RENEWED YEARLY. ANY SIGNIFICANT CHANGES TO YOUR APPLICATION, (ADDRESS CHANGE, MEDICAL CRITERIA, ETC.) NEED TO BE UPDATED WITH THE SPECIAL NEEDS COORDINATOR AS SOON AS POSSIBLE.

IF YOU REQUIRE A SPECIAL NEEDS SHELTER APPLICATION WITH LARGER PRINT, PLEASE CONTACT THE SPECIAL NEEDS COORDINATOR, (321-637-4070), AND ONE WILL BE PROVIDED TO YOU.

Do Not Want Service Form

I have been offered the opportunity to apply for evacuation assistance from the Brevard County Special Needs Program.

I Do Not Want Assistance
for transportation or shelter placement at this time.

If I desire assistance in the future, I understand it is my responsibility to contact the Office of Emergency Management (321) 637-6670

PLEASE PRINT:

Last Name:________________________ First Name:_____________

Client Address: _______________________________________

Client Telephone:____

CLIENT SIGNATURE: ___________________ DATE:_______
Signature of Registrant or Guardian (REQUIRED)

Attending Nurse Signature:_______________ DATE:_______

AGENCY:____

Please complete this form and return to: Brevard County Emergency Management
1746 Cedar Street
Rockledge, Fl 32955
321-637-4088

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