SPECIAL MEDICAL NEEDS PROGRAM
LEE COUNTY EMERGENCY MANAGEMENT

PO BOX 398, FORT MYERS, FL 33902-0398
FOR INFORMATION CALL 239-533-0640 / FAX# 239-477-3636

Applications will NOT be processed when Lee County is in the 5-day hurricane forecast cone.

PERSONAL INFORMATION

First Name		Suffix		Last Name		M.I.	
Date of Birth		Primary language spoken					
Gender		Weight		Height – feet		inches	

PHYSICAL ADDRESS

Address		Street		Unit#	
City		State		Zip Code	
Subdivision/Community		Gate Code			
Residence type (single detached home, duplex, Apt/Condo, boat, mobile/manuf home)		Living Situation (Live alone, Live with Relative, Live with Caregiver, Other			
Number of Stairs		Number of Flights		Utility Company	
Primary Phone		Secondary Phone		7-1-1 Relay/TTY	
Email address					

MAILING ADDRESS

☐ Same as above

Mailing Address		Unit#		PO Box	
City		State		Zip Code	

CAREGIVER INFORMATION

Caregiver First Name		Caregiver Last Name	
Caregiver Primary Phone		Caregiver Secondary Phone	
Caregiver email			
Do you require a 24 hr caregiver?		Will caregiver stay with you at the shelter?	

Applicant's Name

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EMERGENCY CONTACT - LOCAL

Emergency First Name				Emergency Last Name			
Emergency Primary Phone				Emergency Secondary Phone			
Address		Street		Unit#			
City		State		Zip Code		Relationship	
Local Emergency Email							

SECOND EMERGENCY CONTACT

Emergency First Name				Emergency Last Name			
Emergency Primary Phone				Emergency Secondary Phone			
Address		Street		Unit#			
City		State		Zip Code		Relationship	
Emergency Email							

HEALTH MEDICAL ASSESSMENT Doctor Information

Doctor's Name ______ Doctor's Phone Number ______

HHA Provider ______ HHA Contact Name ______ HHA Phone ______

☐ I have a Do Not Resuscitate (DNR). Your original document, signed by your doctor, MUST be with you at the shelter.

SPECIAL CARE ASSESSMENT

☐ Blind/LowVision	☐ Chronic Wounds	☐ Recent Hospital Discharge
☐ Deaf/Hard of Hearing	☐ Decubitus Ulcers	☐ C-Diff
☐ Frail / Elderly	☐ IM or IV Injections	☐ MRSA
☐ Need Asst with Medications	☐ Feeding Tube	☐ Terminally Ill – Hospice
☐ Hemodialysis – at home	☐ Insulin Dependent	☐ Seizures
☐ Hemodialysis – at facility	Hemodialysis frequency ______	

Dialysis/Home Health Center ______ Phone ______

Other ______

______ **Applicant's Name**

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COGNITIVE ASSESSMENT

- ☐ Dementia
- ☐ Conduct Disorder
- ☐ Anxiety
- ☐ Alzheimer's Disease
- ☐ Psychiatric Disorder
- ☐ Depression
- ☐ Developmental Impairment
- ☐ Bipolar Disorder
- ☐ Causes harm to self/others
- ☐ Autism Spectrum
- ☐ Parkinson's
- ☐ Obsessive-Compulsive Disorder

Autism Level (Asperger's-high functioning, Moderate, Low functioning, Non-verbal) ____________

Other ____________

MOBILITY ASSESSMENT

- ☐ I can walk on my own
- ☐ I need an attendant to help with walking
- ☐ I use a standard wheelchair
- ☐ I can stand and walk cane
- ☐ I have a Service Animal
- ☐ I use a motorized wheelchair/scooter
- ☐ Amputee
- ☐ I use a walker/wheeled seat walker
- ☐ Paraplegic
- ☐ White Cane
- ☐ Quadriplegic
- ☐ I weigh over 300 pounds
- ☐ Multiple Sclerosis (MS)
- ☐ I am bed-bound
- ☐ Muscular Dystrophy (MD)
- ☐ I require stretcher transport
- ☐ I need a Hoyer Lift
- ☐ ALS (Lou Gehrig's Disease)

Other ____________

WHAT HELP DO YOU REQUIRE?

- ☐ Walking
- ☐ Toileting
- ☐ Communicating
- ☐ Bathing/Showering
- ☐ Standing
- ☐ Feeding
- ☐ Ostomy
- ☐ Asst with Medications
- ☐ Getting in/out of bed
- ☐ Wound Care
- ☐ Bowel/Bladder Incontinence
- ☐ Dressing
- ☐ External / Self Catheter

Other ____________

ELECTRICITY ASSESSMENT

- ☐ Nebulizer
- ☐ Ventilator
- ☐ Apnea Monitor
- ☐ Feeding pump
- ☐ Refrigerated Meds
- ☐ Cardiac Monitor
- ☐ I require Oxygen

Liters per minute I require ____________

Oxygen usage (24 hrs/day, nights only, as needed, with CPAP/BiPAP) ____________

Oxygen Provider ____________

Phone Number ____________

____________ **Applicant's Name**

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ADDITIONAL MEDICAL INFORMATION

☐ I have allergies

TRANSPORTATION NEEDS

☐ I will provide my own transportation

☐ I need a ride – Paratransit bus

☐ I am bed-bound and require stretcher transport

PET SHELTERING NEEDS

Name	Type	Breed	Weight	☐ Carrier/Crate ☐ Leash/Collar

Pet notes

REGISTRANT INFO

Representative's Name Representative's Phone

Representative's Relationship to Registrant:

☐ Records relating to the registration of special needs citizens are exempt from the provisions of S.119.07(1), Florida Statutes.

I understand this registration is voluntary and do hereby request to be registered in the Lee County Special Medical Needs Program. The information contained herein is true and correct to the best of my knowledge. I understand there are limitations to the services and levels of care that are available.

I hereby grant permission to medical providers, transportation agencies, and others, to provide care and respond to my needs, and for the disclosure of any information necessary to do so. I also grant permission to emergency response agencies to enter my residence for the purpose of emergency search and rescue, and authorize the release of information necessary for these agencies to perform these services.

In an effort to ensure the safety of all shelter residents, a background screen will be run on all people evacuating to the Special Medical Needs Shelter, including the caregiver.

It is not necessary to fill out a new application every year.
Please call (239) 533-0640 once a year to update your application. Thank you!

Applicant's Name