Flagler County Emergency Services
PSN Registration
1769 East Moody Blvd #3
Bunnell, FL 32110

FOLD HERE

PERSON WITH SPECIAL NEEDS APPLICATION

FOLD HERE

FLAGLER COUNTY EMERGENCY SERVICES
PSN REGISTRATION
1769 East Moody Blvd #3
Bunnell, FL 32110

Persons with Special Needs Criteria

All residents are encouraged to have an emergency plan that includes evacuating to a location, such as a friend or family members home, or a hotel, outside of a potential evacuation zone. Hurricanes and wildfires are examples of emergencies that may trigger large-scale evacuations. Hurricanes have pre-determined evacuation zones; please visit www.flaglercounty.org/emergency to identify if you are in a hurricane evacuation zone.

The Persons with Special Needs (PSN) shelter is a temporary facility, **of last resort** (if you are unable to evacuate to another home or hotel), that is capable of providing **limited** medical care to individuals requiring services of a caregiver, or home health care provider, in their everyday activities due to medical conditions and/or disabilities. These shelters cannot offer the same level of care that is available in a hospital or other health care facility.

Supplies at the shelter are limited and it may take several hours, to days, before additional supplies arrive. Evacuees are to bring at least 3 days (preferably 5 days) worth of:

- All medications (in original containers),
- Medical supplies (i.e. gauze, saline, etc.), and
- Personal items (i.e. hygiene products, clothing, diapers, pillows, blankets, etc.) in a small travel bag to the shelter.

To submit an application for registration to PSN shelter, complete this application in its entirety and return it to:

Flagler County Emergency Management
PSN Registration
1769 East Moody Blvd #3
Bunnell, FL 32110

Following a review of your application, Flagler County will notify you of the available services.

All records, data, information, correspondence, and communications relating to the registration of PSNs are **confidential** and exempt from public records requests in the manner outlined in Florida Statute 252.355 (4).

Application for Person with Special Needs Shelter

Please read the instructions and information provided before completing the form.
Full completion of this form is necessary. The return of incomplete forms may be necessary.
PLEASE PRINT CLEARLY

Personal Information – Please Print or Type.

Date of application: ____/____/____

Last name: _____ **First name:** _____ **MI:** _____ **Gender** ☐M ☐ F

Email Address: _____ **Date of Birth**: _____/_____/_____

Height Ft____ **Inches**_____ **Weight** _____**lbs** **Eye Color** _____ **Primary Language Spoken:** _____

PHYSICAL ADDRESS

Address: _____ Apt/Lot #: _____ City: _____State: _____ Zip:_____

County_____ Municipality_____ Subdivision_____

Do you live at the above address all year round? ☐ Yes ☐ No If No, From _____ To_____

Type of Residence ☐ House/ Duplex, ☐ Apt/Condo (What Floor_____), ☐ Mobile Home/Trailer, ☐ Group/Nursing Home

MAILING ADDRESS (if different than physical address):

Address: _____ Apt/ Lot #: _____ City: _____State: _____ Zip:_____

TELEPHONE

Primary Phone: (___) _____ extension: _____ Mobile phone: (_____) _____

Is Primary phone a TTY/TDD line ☐ Yes, Language Needed for TTY/TDD: _____

Secondary Phone: (___) _____ extension: _____

EMERGENCY CONTACT INFORMATION

Please provide contact information for individuals with whom we can discuss your medical situation and needs.

Primary Contact:

Contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other _____

First Name: _____ MI: ___ Last Name: _____ Email: _____

Address: _____ City: _____ State: _____Zip: _____

Primary Phone: (____) _____ Secondary Phone: (____) _____

Secondary Contact:

Contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other _____

First Name: _____ MI: ___ Last Name: _____ Email: _____

Address: _____ City: _____ State: _____Zip: _____

Primary Phone: (____) _____ Secondary Phone: (____) _____

Out of Area Contact:

Contact's relationship to you (check one):

☐ None ☐ Friend ☐ Family Member ☐ Neighbor ☐ Caregiver ☐ Other _____

First Name: _____ MI: ___ Last Name: _____ Email: _____

Address: _____ City: _____ State: _____Zip: _____

Primary Phone: (____) _____ Secondary Phone: (____) _____

Pets and Service Animals

Please Note: **While we may not be able to house your pets in your immediate vicinity at the Special Needs Shelter, we have taken steps to ensure that you can evacuate with your pet.** Flagler County has arranged to shelter pets, belonging to Special Needs clients, or their caretakers, in a different building and/or at a different shelter site in the within the county. Owners are responsible for providing a sufficient amount of food and supplies for their pets for at least 72 hours.

Do you have? Dogs ☐ Yes ☐ No How many _____ Cats ☐ Yes ☐ No How many _____

Birds ☐ Yes ☐ No How many _____ Other Pet ☐ Yes ☐ No Type_____ How many _____

Do you have a service animal (please include in the count above)? ☐ Yes ☐ No Type: _____

Personal Survey Form

Physician's Information

Name: _____ Phone (____) _____ Ext.:_____

Home Healthcare Agency Information

Name: _____ Phone (____) _____ Ext.:_____

Caregiver Information

Name: _____ Phone (____) _____ Ext.:_____

Pharmacy Information

Name: _____ Phone (____) _____ Ext.:_____

Other Healthcare Agency Information

Name: _____ Phone (____) _____ Ext.:_____

Transportation

Do you need transportation to a Shelter?

☐ No, my caretaker or I can drive my personal vehicle to the Shelter

☐ Yes, I have medical conditions and need transportation to a Special Needs Shelter

☐ Yes, I have no Special Needs Medical Conditions and require transportation to a General Population Shelter.

If you checked "***yes***" to one of the above, please check one of the following:

☐ I can walk to, on, and off the bus without assistance

☐ I am mobile with an assistive device (walker/cane)

☐ I require a (check one) ☐ Wheelchair ☐ Electric Scooter ☐ Other _____

☐ I am bedridden, require a stretcher and cannot transfer to a wheelchair or sit for transport.

If you are only requesting transportation to a General Population Shelter, Please skip Medical Information section, read, and sign Applicant Signature section.

Medical Information

Enhanced Care Shelter (may require medical assistance, please check all that apply)

☐ Bedbound ☐Hospice ☐ 24 hour ventilator support ☐ Continuous IV Therapy ☐ Airway Suctioning frequency _____

☐ Bedsores ☐ Weight 350lbs or greater with mobility issues ☐ Oxygen Adjunct Used_____ Flow rate _____

Assisted Care Shelter (may require medical assistance, please check all that apply)

☐ Personal care (feeding, dressing, toileting) ☐ Mobility (walking, transferring) ☐ Guidance (blind, low vision)

☐ Deaf/Hard of Hearing ☐ Skilled medical/ mental healthcare __Intermittent __ Continuous

☐ Wound care, If yes type of wound _____ Location_____ Date last cultured _____

☐ I use medical equipment requiring electricity ___Intermittent ___Continuous Explain _____

POWER STRIP OR CHARGERS ARE REQUIRED TO BE BROUGHT WITH ALL ELECTRICAL EQUIPMENT

☐ List all medical supplies you need to utilize in 72 hours (**PLEASE BRING ALL THESE SUPPLIES WITH YOU)**

_____

_____

I have the following conditions (check all that apply)

☐ Alzheimer's / Dementia __ Early ___ Moderate ___ Advanced ☐ Sensory loss/ impairment assistive device_____

☐ Cognitive/ psychiatric Impairment Type_____ ☐ Neuro-muscular disorder __ Early___ Moderate ___ Advanced

☐ Hip replacement Date of Surgery_____ ☐ Knee replacement Date of Surgery_____

☐ Cerebrovascular Accident (CVA/Stroke) Date of last CVA/Stroke_____ ☐ Dialysis Type_____ Frequency_____

☐ Bladder or Bowel Dysfunction assistive device_____ ☐ Colostomy _____assistive device_____

☐ Catheter Type_____ Frequency of replacement_____ ☐ G-tube feeding _____assistive device_____

☐ Cystic Fibrosis ☐ COPD ☐ Emphysema ☐ CPAP/ BIPAP

☐ Diabetes ☐ Yes ☐ No ☐On Insulin type_____ (Bring personal insulin, glucometer, Glucagon and supplies to shelter)

☐ Psychosis ☐ Controlled ☐ Uncontrolled ☐ Seizures ☐ Controlled ☐ Uncontrolled

☐ Mobility Impairment Assistive device_____ ☐ Dressing changes that need medical assistance_____

☐ Require Assistance taking your medications, type of assistance needed _____

☐ DNR (Do not Resuscitate) **Copy of DNR must accompany person to the shelter**

If you have been hospitalized in the last 3 months for the following:

☐ Congestive Heart Failure (CHF) ☐ Shock due to an internal defibrillator ☐ Open Heart Surgery

Applicant Signature

I certify that this information is correct. I understand that based on this application and the data I have provided, the Flagler County will determine which emergency evacuation assistance, if any, this program may be able to provide. I understand that the provision of assistance will only last for the duration of the emergency and that I must make alternative arrangements should I be unable to return to my home (for example, due to damage).

I also understand that I will be responsible for any charges and costs associated with hospitals, other medical facilities or transportation. I grant permission to medical providers and transportation agencies and others to provide care and disclose/share any information necessary to respond to my needs.

If my evacuation is necessary, and I have requested transportation assistance, I will receive advanced notice, by phone, of the date and time period during which transportation services will arrive. If I decline transportation upon notification, or when those services arrive, I understand that I may not have another opportunity to obtain this service.

☐ **I authorize** ☐ **I do not authorize** emergency personnel to enter my home during search and rescue operations if necessary to assure my safety and welfare following a disaster.

Applicant Signature: _____ Date: _____ Witness Signature: _____ Date:_____

To sign up for weather alerts and other emergency notifications, please visit:
www.FlaglerCounty.org/emergency or www.FlaglerCounty.org/AlertFlagler

Do Not Write Below This Line

Zone: _____ **Reviewed by:** _____ **Date:** _____ **Record No:** _____ **FCHD**_____

PSN Shelter: _____ **Date:** _____ **Notify Only:** _____ **Date:** _____