Pasco County Emergency Management

Special Needs Registration Form

Applicant Information

Full Name: _____ Date of birth: _____
Last *First* *M.I.*

Address: _____
Street Address *Subdivision/Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone number: _____ Email: _____

Gender- Male ☐ Female ☐ Do you live alone? ☐ YES ☐NO Do you have a service animal? ☐ YES ☐NO

Caregiver: _____ Caregiver Phone Number **:** _____

Does your caregiver live with you? YES ☐ NO ☐ Do you have any non-service pets? YES ☐ NO ☐

Do you live in a mobile home? YES ☐ NO ☐ Do you live here full time or seasonally? _____

Emergency contact/ Phone number/ Address: _____

Healthcare Provider Information

Home Health Agency: _____ Phone Number: _____

Primary Physician: _____ Phone Number: _____

Medical Conditions

☐ Bedridden ☐ Wheelchair ☐ Walker ☐ Ventilator ☐ Continuous Equipment ☐ Over 300 lbs ☐ Combative/violent

☐Nebulizer ☐Concentrator ☐CPAP ☐Oxygen Dependent- Hours per day: _____Liter Flow: _____

☐Alzheimer's ☐Dementia ☐ Mobility Issues ☐Contagious Disease- Which one? _____

☐Communication Difficulty ☐Wound Care ☐Incontinent ☐Dialysis- How frequent _____

☐Diabetic ☐Insulin Dependent ☐Feeding Tube ☐ Ileostomy/Colostomy ☐Heart Disease ☐Blood Pressure

☐Stroke ☐Visual Impairment ☐Hearing Impairment ☐Neurological Condition- Explain: _____

☐ Cancer- Is it being treated, if so explain how: _____

Transportation

☐ I will provide my own transportation ☐ I need transportation ☐ I require a wheelchair lift bus/van and transportation

Acknowledgment - Please Read Carefully

The information contained herein is true and correct to the best of my knowledge. I have read the letter and the Special Needs Shelter Fact Sheet accompanying this request, and I understand the limitations on the services and level of care available. I understand that this registration is voluntary and hereby request registration in the Pasco County Special Needs Program. I also understand that this registration *does not* guarantee my access to a Special Needs Shelter. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I hereby grant permission for the release of this information to emergency response agencies and pre-authorize these agencies to enter my residence for the purpose of emergency search and rescue.

SIGNATURE: _____ **DATE:** _____

REPRESENTATIVE (If you are unable to sign): _____

RELATIONSHIP TO THE APPLICANT: _____

Please Return Form To:
Pasco County Department of Emergency Management
8744 Government Drive, Bldg. A, New Port Richey, FL 34654
For more information call: 727-847-8137

(For Official Use Only)

Reviewed by: **Date:**