# TRANSPORTATION AND SPECIAL NEEDS REGISTRY APPLICATION

Brevard County Emergency Management
www.embrevard.com

EMAP Accredited – Emergency Management Accreditation Program

**COMPLETE ONE APPLICATION PER PERSON – THIS IS A VOLUNTARY, FREE PROGRAM.**

Transportation is free to all General Population Shelters and Special Needs Shelters.

## PERSONAL INFORMATION (Section A)

First Name: _____ M.I. _____ Last Name: _____

Birth Date: _____ Gender: ☐ Male ☐ Female

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

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

Name of Complex/Subdivision/Condo or Development _____

Home Address: _____ Apt./Lot #: _____ City:_____

Zip Code:_____ Home Phone: _____ Cell Phone: _____

Mailing Address (if different from above): _____

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

Name: _____ Phone: _____

Other persons, if any, accompanying you to the shelter: _____

_____

Contact **NOT** living with you (in case of an emergency): Name: _____

Relation: _____ Cell phone: _____ Home Phone: _____

## PETS AND SERVICE ANIMALS (Section B)

**Please Note: Pets are NOT allowed in Special Needs Shelters, but Animal Services will pick up and take care of your pet while you are within a Special Needs Shelter.**

Do you have: Dog(s) ☐ Yes ☐ No How many: _____ Cat(s) ☐ Yes ☐ No How many: _____

Do you have a service animal? ☐ Yes ☐ No Type: _____

## TRANSPORTATION (Section C)

Do you need transportation to a shelter?

- ☐ No, I or my caretaker can drive a personal vehicle
- ☐ 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 above, please check one of the following:

- ☐ I can walk to, on and off the bus
- ☐ 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 for transport

**IF YOU ARE ONLY REQUESTING TRANSPORTATION TO A GENERAL POPULATION SHELTER, PLEASE STOP HERE.**
**ALL CLIENTS WITH MEDICAL NEEDS SHOULD COMPLETE ENTIRE FORM.**

---

**Please complete form and return to: Brevard County Emergency Management**

**1746 Cedar Street, Rockledge, FL 32955 | Phone: 321-647-4070 | Fax: 321-633-1738**

## MEDICAL CONDITIONS (Section D)

**Enhanced Care Shelter** (Requires medical assistance, please check **ALL** that apply):

- ☐ Bedbound
- ☐ Hospice
- ☐ 24-hour Ventilator Patient
- ☐ Continuous IV Therapy
- ☐ Bedsores
- ☐ Weight 350 lbs. or greater with mobility issues

**Assisted Care Shelter** (May require medical assistance, please check **ALL** that apply):

- ☐ Bladder & Bowel Dysfunction
- ☐ Colostomy
- ☐ Catheter
- ☐ Oxygen
- ☐ Medical Dependence on Electricity
  - Type _____
  - Type _____
- ☐ Cognitive/Psychiatric Impairments
  - Type
  - Type
- ☐ Trach Tube – that may require suction
- ☐ Dialysis
- ☐ Sensory Loss/Impairment
  - Assistive Device: _____
- ☐ Mobility Impairment
  - Assistive Device: _____
- ☐ G-Tube Feeding
- ☐ Dressing changes that need medical assistance
- ☐ Seizure Disorder

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

If you have been hospitalized in last 3 months for:

☐ Congestive Heart Failure ☐ Shock due to internal defibrillator ☐ Open heart surgery

Currently receiving home health care: ☐ Yes ☐ No Reason _____

Require assistance taking your medications: ☐ Yes ☐ No Type of Assistance _____

---

**Please bring all medications with you to the shelter. Please list medications below:**

_____

_____

_____

## **SUPPORT AGENCIES** (Section E)

Healthcare Agency: _____ Phone: _____

Contact Person: _____ Phone: _____

Doctor/Physician: _____ Phone: _____

Contact Person: _____ Phone: _____

Insurance Provider: _____ Phone:_____

Contact Person: _____ Phone: _____

Medical Equipment Provider: _____ Phone: _____

Contact Person: _____ Phone: _____

Other Healthcare Agency: _____ Phone: _____

Contact Person: _____ Phone: _____

## **TRANSPORTATION AND SPECIAL NEEDS REGISTRY AGREEMENT** (Section F)

I understand that a Special Needs Shelter does not provide beds, cots, or lifts, and that I should plan to bring my own, and that assistance will only be provided for the duration of the evacuation and in the event I am not able to return to my home that I will be responsible for any additional transportation/hospital expenses. I understand Emergency Management will determine if any emergency evacuation assistance will be provided. I understand that power is not guaranteed, due to unforeseen power fluctuations or power failures.

Upon order or recommendation to evacuate, 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. If I decline transportation when a transporter arrives, I understand that I may not have another opportunity to obtain this service.

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. I certify that this information is correct to the best of my knowledge. My caregiver (if one is assigned) will be present during my stay at the shelter.

_____ _____

Applicant Signature Date

If the person completing this form is not the patient, please state:

Name: _____ Phone: _____

Relationship/Agency: _____